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Saturday 5th of November 2011



"Perhaps my greatest satisfaction has been in the hard won rewards of a major piece of research. I have supervised over 15 Doctoral theses, and when we have the 'robing ceremony' at Aalborg, and I can see the pride and joy of a doctoral researcher after they have successfully defended their thesis, then I am really wanting to clap and applaud and cheer."

(Wigram, T. 2007)

VOICES:

A World Forum for Music Therapy includes an Open Access journal and encourages participation from every culture of music therapy. The journal nurtures the development of practice and research, theory and discussion. Because culture has an important role in music and music therapy, we encourage contributions that find their source in the cultural influences of each country.

This vision of Voices is shared by an international editorial board with editors from all the six continents. When the journal and forum was established in 2001, the most prominent genres were essays, stories, reports, interviews, and discussions. We will continue to develop a space for these "Original Voices." In addition, our journal is currently developing a new section called "Research Voices," where the texts submitted will have a research foundation. All articles are given a thorough peer-review.

Editors-in-Chief:

Cheryl Dileo

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COMMEMORATIVE SEMINAR. THE ACADEMIC LIFE OF PROFESSOR TONY WIGRAM.

Aalborg University. The Faculty of the Humanities
Department of Communication and Psychology



ARTICLES FROM
VOICES 11(3). NOVEMBER 2011.

Voices
A WORLD FORUM FOR MUSIC THERAPY

10.30 – 11.00: Arrival and coffee/tea.

11.00 – 11.20: Welcome/song. Tony's academic contribution to the MA-Programme of Music Therapy.

Prof. mso. Inge Nygaard Pedersen. PhD. / Ass. Prof. Ulla Holck. PhD. Aalborg University. DK

11.20 – 11.30: Tony's academic contribution to The Faculty of Humanities. Dean, The Faculty of Humanities, Lone Dirckinck-Holmfeld, Aalborg University. DK

11.30 – 11.40: Tony's academic contribution to The Department of Communication and Psychology. Head of the Department. Christian Jantzen. Aalborg University. DK

11.40 – 11.55: Tony's contribution to development of The Doctoral Programme in Music Therapy at Aalborg University. Ass. Prof. Lars Ole Bonde. PhD. Aalborg University. DK

11.55 – 12.10: Tony's contribution in bringing The Doctoral Programme in Music Therapy to where it is today. Prof. mso. Hanne Mette Ochsner Ridder. PhD. Aalborg University. DK

12.10 – 12.45: LUNCH

12.45 – 13.00: Commemorative Concert. Jenny Wigram & Michael Wigram. UK

13.00 – 13.30: Tony's academic contribution to the research milieu of music therapy at Anglia-Ruskin University, Cambridge and in the UK. Prof. Helen Odell-Miller. PhD. Anglia-Ruskin University. UK

13.30 – 14.00: Tony's academic contribution to the research milieu of music therapy at Melbourne University, in the AUS and the Consortium of Nine Universities. Prof. Denise Grocke. PhD. Melbourne University. AUS

14.00 – 14.30: Tony's academic contribution to the research milieu of music therapy at Temple University, Philadelphia, USA, in the WFMT and the Consortium of Nine Universities. Prof. Cheryl Dileo. PhD. Temple University. USA

14.30 – 15.00: Tony's academic contribution to world conferences in Music Therapy to AMTA and to books on Music Therapy Research. Prof. Barbara Wheeler. PhD. Louisville University. USA

15.00 – 15.15: Coffee/tea

15.15 – 15.45: Tony's academic contribution to the Cochrane Reviews in Music Therapy, to RCT research projects and to the research milieu in Bergen. Prof. Christian Gold. PhD. Uni Research, Bergen. N

15.45 – 16.15: Tony's academic contribution to The Nordic Journal of Music Therapy and to the Nordic research milieu of music therapy. Prof. Brynjulf Stige. PhD. University of Bergen. N

16.15 – 16.30: Tony's contribution as a PhD-supervisor - during the study and after the defence. Ass. Prof. Cochavit Elefant. PhD. University of Haifa. IL

16.30 – 17.30: Reception and Ceremony.

19.00 – 24.00: Dinner at The Kings Hall, Hotel Phønix. Aalborg.

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was good, and I think it's great you made it." And I was always very, you know, enthusiastic about what people were prepared to contribute. Because it takes time to write a paper, and it's putting your head on the block, because you can always get chopped down by people who are either jealous or don't want to listen to what you've got to say. But almost always I've complimented people, especially people who have been prepared to present their clinical work. Because I know that people really want to hear about the clinical work. So we've always put an emphasis on people presenting their video excerpts and things like that, and that's terribly important. A lot of people have put lots of good things into these European conferences. And it's taken a lot of effort from people, and I'm sure that people haven't always agreed with some of the stuff that goes into those papers. But if they formulated a case presentation or if they formulated a good enough video presentation, I am willing to listen to it and always would. You know. It's good.

LO: I think indeed - I haven't been to all conferences, but I remember that in the early years, you could hear case presentations that were purely anecdotal. Nobody does that anymore I think. They come with their documentation, video or audio or other material, and give a proper presentation of what they've done.

TW: I think that's very important, I think that's been one of the biggest developments over the last ten years - the stakes are being raised, and people certainly say: "Yes, we've got to do good here because, well, our work is being presented in front of quite a few different people." I think that that's one of the best things that has

developed: raising the level, without being competitive. But the quality of some of the papers even at the early EMTC conferences was still good, I think. People thought carefully about what they wanted to say, and they said some good things - our early keynotes for example.

IN: And you did a great keynote in the latest European conference in Cadiz 2010. We heard yesterday that people were so impressed, maybe it was the best you've ever done.

TW: Yes, the one I put together for Cadiz I was really pleased with. I've done lots of different keynotes in my time. Some of them I've been pleased with, and some of them haven't been so good. One of the ones I liked best was actually the one I did for the Norwegian conference in Bergen 2007. They invited me to present all my old clinical work, with my videos of my work with music and movement and my work with the learning disability population - all the things I have been talking about here. That was a really nice keynote to do, and I think it actually hit the Norwegians. That was really the sort of work they liked anyway.

LO: Would you say there has been an improvement in the discussion culture over the years? More respect?

TW: I think definitely more respect in terms of the discussion and more respect in terms of when people are trying to argue a point. People will listen more, too. I hope they do anyway.

“An Englishman in Denmark”

What have I learned from Dansk Musikterapi?

By Tony Wigram

Introduction – Where was I professionally in 1992?

In 1992, I was the manager of a Department of Music Therapy in a large hospital, a District Officer of Paramedical Services, a Mental Health Officer, a research psychologist, clinical supervisor, and was heavily into music therapy politics in the UK and Europe. I was also an occasional [annual] teacher on fledgling music therapy courses in Italy and Spain, a church organist and choirmaster, and father of three small boys.

I was trained in 1974 by one of the pioneers of music therapy, Juliette Alvin, on a very short, one year post graduate course. The course involved a quite limited study of theory, therapy methods and psychology, together with continuous clinical practicums – we were assigned one day a week, 12 weeks practicums in each of the three semesters to three different clinical settings, throughout the course. The main strength of this programme was that it required a high level of music skill – Diploma level [needed to get into conservatoires] before they would accept you. Over the years my travels around Europe have allowed me to see many different criteria for admitting students to MT courses, and the need to have well developed musical skills is by far the most important, in my opinion. We can teach theory, psycholo-

gy, scientific and therapy knowledge and skills in a 2-5 years course quite easily, but it is impossible to teach someone to be a good enough musician – that is a training that starts back in childhood, unless someone has latent and very good talents. But this course in Denmark was already then 4 years long [becoming 5 in 1996] – WHAT A COMPREHENSIVE EDUCATION – LUXURY!!!!

So there I was – content in my clinical, musical and political world with already enough to do, and many research projects actively going on, when suddenly out of the blue, an invitation came to join a small team in Denmark, in a town I had never heard of, for just a year...? How could I resist !!!! – especially with the delights of the Danish winter!

The year became two, then three....four ... five ... ten ... FIFTEEN!! I have now been here in Aalborg for 15 out of the 25 years that the course here has been running, and for the entire period of time that the Doctoral Research School has been developed. While my Danish language is merely functional, and pathetic at a social level – I feel very much part of the Danish situation, and am proud to wear the badge of Denmark on my breast at Conferences, Seminars and International meetings.

Captured by the Danes!!

What did I come to Denmark with? ... Years of experience in the clinical field and years of experience of music therapy politics. In fact, that was how Denmark found me – I was building up the European Music Therapy Confederation, and also working on an unfortunately named music therapy internet communication system called DICS [Data Information and

Communication System]. Hanne Mette Kortegaard was, at the time, the Danish representative on the EMTC. I was actually ‘head-hunted’ to come and work in Denmark JUST for one year to start with, and then for a further year. I vividly remember my ‘interview’ at King’s College Cambridge during the European Conference of April 1992. Inge had dressed for the occasion, complete with fashionable and impressive make-up, and all three of them [Inge, Lars Ole and Hanne Mette] just looked at me and explained how WONDERFUL it was in Denmark and that I must come!! Any attempt by me to try and find out what I was supposed to do there, whether I had the necessary skills, knowledge and experience to teach music therapy or any other relevant facts about the job was almost completely avoided by these three lovely people, who simply wanted me to come here. It didn’t seem my worries about my competence to teach really bothered them at all. In fact, when I arrived, I was told quite clearly by the Institute leader that Aalborg was hiring me for my research work – not teaching. Teaching was just a necessary by-product [I want to say I have never seen it that way, and nor do all my colleagues – we all count teaching students as very satisfying].

As I had very little teaching experience in music therapy, compared to my clinical and research experience, I was significantly more doubtful about this optimistic attitude, and when I actually arrived in Denmark in August 1992, clutching several thousand pounds in my hands to buy a house in Uggerhølle [near Vodskov], and with the best of intentions – I became quite uneasy at their expectations that I would teach subjects about which I had quite patchy know-

ledge!! Music Therapy in England was very short on theory, but long on musical and therapeutic skills. So the strong and extensive theoretical component of the Aalborg programme was actually quite new to me. Luckily, they put me on to teaching individual piano – which I did have SOME confidence about!! But the theory of therapy, terapirettet sammenspil, psychology of music – well, these needed a lot of preparation and thought. I think my first students in 1st, 3rd, and 5th semester looked at me in a rather bemused way – perhaps even cross eyed, as I struggled in those first two years. All I can say is that then – and EVER SINCE, I have been so impressed by the respectfulness, kindness and tolerance of all the students I have taught. In fact, the decision not only to come and work in Denmark, but also to stay here, was one of the best ever decisions of my life [after marrying my wife!], and I feel absolutely privileged and lucky to have had this chance. This is not only because I have had so much fun teaching and researching, but also because of the wonderful colleagues I am working with here. They are simply the best, and the rest of the music therapy academic world is sometimes quite jealous of our team and the relationships within it.

My first house in Denmark, affectionately known as the ‘Villa Tasteless’ became a little symbol of the growing internationalisation of the programme. We had a constant stream of internationally famous guest teachers, including Clive and Carol Robbins, Ken Bruscia, Henk Smeijsters, David Aldridge, Lisa Summer, Even Ruud, Cheryl Dileo, and many many others. Most of them spent time at ‘Villa Tasteless’ and signed their names on the famous Wall [at one end of the living

room was a wall with brick design wall-paper – it became covered in signatures of guests, staff and students]. A regular visitor [lodger] and supporter at this time was the lovely Inge Nygaard Pedersen – seen here preparing to set out for work in the depths of the Danish winter.

What did I find?

The education in music therapy in Denmark was, in 1992, relatively unknown in both Europe and the World. Yet many elements of this education, which my colleagues here took for granted as quite natural and completely essential, were for me extraordinary and unexpected. Since then, and also since the music therapy programme at Aalborg became a 5 years, full time, Bachelor/Masters education to cand.mag level, I have basked in the reflected glory and fame of such a comprehensive and extensive training – watching with delight the wonder and envy on the faces of many colleagues in Europe, USA and Australia. For example, the music part of the training in many other educations I have had contact with do not specialise on the specific needs of music therapists – whereas in Denmark I found music training that equipped the students with more appropriate skills. There was a significantly more comprehensive component on theory, scientific thinking, therapy concepts and psychology than I was aware of elsewhere in Europe.

The ‘jewel in the crown’, and the most important element in the training was how much self-experience was included throughout. The individual and group therapy, group leading, inter-therapy, KGMF [Clinical Group Music Therapy Skills] and group dynamics formed a

comprehensive and continuous part of the programme, and really helps the students begin their professional work with a strong grounding in themselves. This was quite unusual even for European trainings and, at the time, unheard of in the USA. In fact, in a conference in the USA in 1997, I took part in a discussion of music therapy educators about self-experience. I explained the Aalborg Model, and in response to a proposal that student therapists in the US would benefit from personal therapy, an educator commented that they were too young and immature to be able to go into that. This was an interesting comment, and I pointed out that these ‘young’ students were actually being trained to ‘do’ therapy to others, so how could they be too young for therapy themselves. The answer to this was that in the US they were trained only to do activity therapy, not insight based therapy [although I am sure that is not now the case across all trainings]. So I found that Aalborg was very much leading the way in this area of training. Trainings in the UK require individual therapy, but not necessarily music therapy [and interestingly, most students choose verbal psychotherapy]. Aalborg ensures students have experience in individual and group music therapy.

Perhaps the weakest area in the Danish training was practicum experiences. When I came, students went on an observational placement for 4 weeks in the 2nd semester, and then next experience with clients did not come until the 7th semester with the long, 6 month practicum. So there were three years of study without almost any contact with the clients. This was something I was able to find a way of changing when the

programme became a five years study, including observation practicums in the 5th and 7th semester, and experience of working with patients in the 6th and 8th semesters. This has all been further developed since.

The early years

Learning to teach was a challenge and a pleasure. Danish students are respected all over the world – and I know this from the great feedback I have had from all the guest teachers who have visited and taught. They are mature, enquiring, argumentative, reflective and reflexive. In fact, these years of the 1990’s, together with all my experience from clinical work and research, proved a very maturing experience for me. I could have left in 1994 – gone back to my job in England. So why didn’t I??

Well first, England had stopped being so attractive since Mrs Thatcher – the ‘Iron Lady’ imposed her beliefs and practices on us – particularly in the National Health Service where I worked. It became a market – buying and selling, with armies of managers, administrators, accountants, and major changes occurring almost every year. It has not been better under Blair – so with hindsight I made an excellent decision to continue my work and development in Denmark. Second, I was blessed with two of the most remarkable and like-minded colleagues any one could wish to work with during those early years – Inge and Lars Ole. Third, Denmark really invested in universities at this time, and our brilliant Dekan – Ole Prehn, invested in Music Therapy [even though he was often heard complaining about how expensive we are!!].

Studieleder

I think it was Lars Ole’s crazy idea that in 1995, I should take over from Inge [to give her a rest after an unbroken 13 years] as studieleder. It coincided with a decision by the Ministry of science to make an evaluation of two chosen programmes in Aalborg [one of them was music therapy] and also a decision that the course should convert from a 4 to a 5 year training. These two extensive projects took a lot of my time during this period [1995-1997], but creating the 5 years programme was a very exciting process. I was also distracted by becoming President of the World Federation of Music Therapy at this time. I am sure that the teaching team found it hard work at meetings to cope with all my odd ideas, my pigeon Danish, and my international commuting. Again, they were very tolerant and supportive, and I thank them all for that now.

The development of the programme into a five year training took two years, and it has been continually adapting ever since. We have also had a bunch of 20 former students, now experienced clinicians, who came back for the efteruddannelse 2001-03 – which was another incredibly worthwhile project. Everything seemed to be exploding from 1995 onwards, with a long and exciting period of development that is, in many aspects, still continuing now.

The professor – research and writing

The period from 1997 to 2007 has been very productive, and also quite exhausting. I was incredibly honoured when both Lars Ole and Inge supported [even demanded of me] my appointment as

Professor – and I was very grateful when Lars Ole took over as studieleder, leaving me clear to work hard on the Forskerskole. I think this is when the full impact of the ‘Aalborg Effect’ began to drive my work. The Faculty had offered us a generous opportunity to build a proper forskerskole, tap into the enthusiasm for research, and internationalise our research school, and we made VERY good use of the money. I encouraged many colleagues in Europe and farther a-field to register on the PhD programme, and a period of building the milieu resulted in what we have today. Alongside this, I began an intense period of writing, and have produced a book almost every year since 1995. The recent books on methods and techniques have come out of my strong conviction that we needed clear teaching and clinical practice tools to consolidate and complement the case study and theory books already on the market.

This period of publication productivity I defined as the ‘Aalborg Effect’, and the way this works is to give one the narcissistic and grandiose idea that all the people out there want to know what you do, think, theorise, practice ... with the result that writing becomes almost a compulsive exercise, a ‘pathology’ – as demonstrated by the figures below:

	Before 92 [1975-1992]	After 92 [1992-2007]
Books	1	18
Articles	13	28
Chapters in books	3	73
Conference papers	12	119

There are now at least 50 times the books available now in music therapy as there were when I trained, and it becomes increasingly difficult to know what to recommend amongst the vast array of written resources. It shows how much more specialised we are becoming as a discipline and profession.

Perhaps my greatest satisfaction has been in the hard won rewards of a major piece of research. I have supervised over 15 Doctoral theses, and when we have the ‘robing ceremony’ at Aalborg, and I can see the pride and joy of a doctoral researcher after they have successfully defended their thesis, then I am really wanting to clap and applaud and cheer.

Postscript

The title of this article for the celebration of 25 years of Musikterapi in Aalborg was also “...what have I learned from Dansk Musikterapi”. Well, to answer that would require another 10 pages. I have learned a lot, gained a lot and as a consequence achieved a lot. I think that the Denmark milieu – both the 5 year training programme and the Doctoral research school, is an inspiration. It has certainly inspired me, and many others who have come. Both of these educations are now internationally famous and respected. So my learning has been mostly about the depth and complexity that is possible in a music therapy training, the variety and stimulation that has come out of research, and the creativity and enthusiasm that emerges from working with a dynamic team that has grown to include Inge, Lars Ole, Ulla, Niels and Hanne Mette, and also includes all the loyal, experienced and excellent teaching staff of the programme.

Of course there is a seemingly never ending process of change going on. Sometimes I think we ought to make an agreement that we will work for two complete years without anyone coming up with a new idea, or anybody at a higher level requiring any change!! Resistance to change is, by the way, a sign of ageing!!! Denmark is a small, dynamic and exciting country, and as well as feeding my intellectual and practical needs, it has of course provided fun and games for my family who, when the boys were small, were visiting for holidays. So perhaps in the final part of this postscript I can reflect on one special symbolic aspect of Danish culture – Lego.

Lego is about building and constructing. It appeals particularly to boys, as they are biochemically predisposed to play with structure, construction, systems etc. Latest research in Autism Spectrum Disorder shows raised Testosterone levels in the amniotic fluid of autistic babies – leading to this type of ‘Extreme Male’ behaviour! So my boys came here and enjoyed Lego, Legoland – a real Danish tradition. But for me this can also symbolise building something – and maybe that is one of the most important things I have gained and learned from being in the Danish Milieu – we have really built something here!!!



Tony Wigram's Work and Influence in Denmark.

*By Inge Nygaard Pedersen,
Aalborg University*

Tony Wigram was recruited to a fulltime Associate Professor position in the Department of Music and Music Therapy at Aalborg University in 1992. We were all convinced that he was the right person to supply and inspire the music therapy milieu there, and we were so right!!

Before starting he wrote a letter with a thousand questions – he wanted to be so well prepared. At the end he wrote „my brain is beginning to run out of thoughts at the moment, but I guess I will have a few more questions in due course. Forgive me if I am a little bit demanding of all sorts of information, it is part of my personality disorder!”

Thank God for Tony's personality disorder! He came and saw and won! He won the trust and admiration of all of us, and he was most deserving to assume the first Full Professor position in Music Therapy at Aalborg University in 1998.

Tony was very respectful and accepting of what was already established – he did not just put in his own ideas unless we all agreed, even if he was always so full of new and bright ideas. He gradually introduced more disciplines in the track of music training and the track of scientific training. He was the first to introduce quantitative research models and the neuroscience theory among other topics. The track of therapy training [self-

experience and methodology] had been well developed, but gradually a better balance between the three tracks was established; and the platform of the five- year, fulltime music therapy education program was established.

Tony introduced other topics into the training including clinical improvisation, which is very popular among the students as it provides them with useful tools for improvisational music therapy work. He also introduced clinical group music therapy skills where the students roleplay different groups of client populations and take turns in pairs to lead the group with pre-, direct- and post-supervision. Tony further developed content in theories of therapy and music therapy as well. As a result of these additions to the training program, an eclectic education for the students was achieved with self-experience and music therapy methods as the glue.

Tony was very open-minded regarding the range of approaches and methods in music therapy internationally. He was at the same time very critical and very supportive concerning all levels of professional development. He received high ratings for excellence from students on his teaching, and Danish music therapists today are very grateful for what Tony has given them both professionally and personally.

As a colleague, Tony was extremely generous. His energy and humour were invaluable in the face of financial cutbacks and overly restrictive administrative and academic policies. Tony was able to “play” with all of his responsibilities – administrative papers, his own publi-

cations, new ideas, organizational matters and new initiatives. Tony's schedule involved being in Aalborg for two weeks and then elsewhere for the following 2-3 weeks. However, he was always informed and prepared as soon as he entered the door to his office. Occasionally his colleagues and I thought that we could keep up with him when he was there only because he was not there every week! He never failed to bring lots of sweets and good wine for late afternoon meetings and he very often cooked for us all and for the PhD students.

His humour was unsurpassed. Often before lecturing he handed out a page of jokes to start the day with a good laugh. He even organized his joke pages in a file in his office just as he organized every single piece of paper that crossed his desk during the 19 years in Aalborg. According to another close friend and colleague, Lars Ole Bonde, Tony's office reflected his personality as a mixture of a systematist and a partygoer. Tony collected all sorts of funny ‘kitsch’ items and colored string lights and placed them in the office or in his flat.

As a musician Tony, was always in the centre when we had parties and meetings – playing the piano for community singing or playing classical piano, orchestra or opera pieces. Classical music – often operas – bellowed from his open office door when he was not supervising students there. He inspired the students to create matinees and just play music for each other; community music certainly grew with his energy and presence.

Last but not least Tony put Aalborg University and its Music Therapy Pro-

gramme “on the map.” Even before the university actively encouraged the staff to create an international profile, Tony had created, for all on the team, a very valuable international network. The last network he created was The Consortium of Nine Universities; we are very proud and happy to be members of this group together with the most outstanding music therapy researchers in the world. The international PhD-Research School is another of his rapidly expanding international projects with 26 students and a wide range of supervisors and guest teachers.

I often called Tony, “THE LIGHTHOUSE” of music therapy who surpassed the music therapy profession all over the world. Through his light and bright ideas he helped so many music therapists find their way both clinically and through research.

I am certainly grateful to have been one of Tony's close friends and colleagues. I will never forget him.

Postgraduate Training in Music Therapy Research at Aalborg University. An international Enterprise.

By Lars Ole Bonde

From 1997 to 2010, Professor Tony Wigram was Head of what was then called "The Graduate School of Music Therapy Research" [from 2009 "The Doctoral Programme in Music Therapy"]. In those years he transformed a small Scandinavian research training network into a full-scale international and worldwide acknowledged program where young as well as mature clinicians from four continents have learned their research skills and defended their research projects. With 26 students in 2011, the program is now the largest music therapy research training program in the world.

This article presents a brief history of the training program and reports from an empirical study of how 13 PhD students [graduated between 1998 and 2005] disseminated their research.

Until 1993, researcher training of music therapists in Aalborg was an individual enterprise, with only one candidate [Barbara Zimmermann Friis] graduating [1994]. In 1993 music therapy was acknowledged as one of two PhD programs in the [at the time] Department of Music and Music Therapy. In the same

year, Associate Professor Inge Nygaard Pedersen received a three-year grant from the Nordic Research Academy [NorFa] to build a Nordic Network of Music Therapy Research. The creative and intense work of the network took place in seminars at beautiful old castles, and the results are documented in a report [Pedersen & Mahns, 1996]. Among the guest teachers were David Aldridge, Ken Bruscia and Daniel Stern; the quality was very high from the beginning. Colleagues from the Nordic training programs in music therapy participated together with a small group of students, including Niels Hannibal and Ulla Holck who both received full stipendates, and Torben Moe, Wolfgang Mahns and Gudrun Aldridge who first studied on a scholar-ship basis and had their last year of study fully financed. Inge Nygaard Pedersen was the formal leader of the PhD program/Network for the first three years, assisted by Lars Ole Bonde and Tony Wigram.

In 1997, Tony was named head of the program, and from then on, The Graduate School of Music Therapy Research at Aalborg University grew into something very special. He managed to get huge grants to develop the program, first in 1997, later in 2004 and also in 2010. Regular PhD courses, supervisor training, and post-doctoral support were parts of the recipe. The list of guest teachers and examiners [Wigram, 2007] is a true "Who's Who" of leaders in the field, and quality control was secured through the involvement of an international board.

The list of the first 16 completed and defended dissertations show some of the characteristics of the program: students

from many countries, a mixture of young talents and more mature students, a broad range of clinical areas and issues, and process as well as effect studies.

Table 1. PHD dissertations in music therapy defended 1998-2007 (English titles)

Mahns, W. (D) (1998). <i>Symbol development in analytical music therapy with children.</i> (written in German)
Aldridge, G.(D) (1998). <i>The development of a melody in the context of improvisational music therapy</i> (written in German)
Hannibal, N. (DK) (2001). <i>Preverbal transference in music therapy</i> (written in Danish)
Moe, T. (DK) (2001). <i>Restitutional factors in group music therapy with psychiatric patients, based on modified GIM</i> (written in Danish)
Holck, U. (DK) (2002). <i>'Commusical' interplay in music therapy. Qualitative video analyses of musical and gestural interactions with children with severe functional limitations, including children with autism.</i> (written in Danish)
Aasgaard, T. (N) (2002). <i>Song Creations by Children with Cancer - Process and Meaning.</i>
Elefant, C. (Isr) (2002). <i>Enhancing Communication in Girls with Rett Syndrome Through Songs in Music Therapy.</i>
Ridder, H. M.(DK) (2003). <i>Singing Dialogue. Music therapy with persons in advanced stages of dementia. A case study research design.</i>
Gold, C. (A) (2003). <i>An analysis of long-term music therapy intervention with mentally ill children and adolescents in Austria.</i>
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Kim, J. (Kor) (2006). <i>The Effect of Improvisational Music Therapy on Joint Attention Behaviours in Children with Autistic Spectrum Disorder.</i>
Odell-Miller, H. (UK) (2007). <i>The Practice of music therapy for adults with mental health problems: The relationship between diagnosis and clinical method.</i>
Pedersen, I. N. (DK) (2007). <i>Counter transference in music therapy.</i>

The first 13 projects were included in my study of how this research was disseminated and what careers the researchers had after their defense. If we take the last question first, it becomes clear that the PhD study had a significant influence on the researchers' status. [See Table 2]

Based on information from the 13 re-

searchers plus databases, I have documented how and where the researchers have disseminated and presented parts of their research, both during their PhD training and after their defense. The following table illustrates publications and other forms of dissemination after the defense. [See Table 3]

Table 2. Career paths of 13 graduates (2007)

1 researcher (Mahns) left music therapy and became head master of a German public school
 1 researcher (Moe) continued as a clinician, with support and new options for research
 2 researchers (Backer, Bonde) were already university professors and continued as such
 9 researchers (the rest) obtained fulltime or part-time positions at music therapy training programs in 4 countries (Denmark, Norway, Germany, Australia)

If the last three of the 16 are included the numbers according to category are: 1 / 1 / 4 / 10

Table 3. Publications and other dissemination of 13 PhD candidates after their defence, anno 2007

n=13	Books	Pdf.-public	Articles with PR	Chapters with PR	Articles other	Chapters other	Conference present.	Other
Year 1	0	9 (7)	6	7	3	1	21	7
Year 2	1	2	6	7	4	1	31	7
Year 3	1		4	4	1	4	12	6
Year 4	0		6	6	1	1	9	3
Year 5+	2		3	4	2	3	13	3
Total	4	11 (9)	27	24*	11	12	86	26
Mean	0,31	0,85	2,08	1,85*	0,85	0,92	6,62	2

In column 1 each year after the defense is given. In 2007, for some candidates 10 years had passed since their defense, for others only two. Therefore, the numbers in rows 3,4 and 5+ would increase with the inclusion of entries after 2007.

Column 2 indicates how many dissertations that were published as books [more or less revised].

Column 3 indicates how many dissertations were publicly available for download in 2007. [It was always Tony's policy that dissertations should be accessible from the homepage].

Column 4 gives the number of articles published in journals with peer review.

Column 5 gives the number of chapters or articles in peer-reviewed books.

Column 6 and 7 give the number of publications without peer review

Column 8 gives the number of presentations [keynotes, papers, posters] in national and international conferences.

Column 9 indicates presentations in public media [radio, TV, newspapers etc.].

The list is quite impressive, and Tony was satisfied with the efforts of his students, who also published during their enrollment and continued to do so after 2007.

Some conclusions related to the tables presented here:

- A PhD project in music therapy at AAU has an "afterlife" of a minimum of 2-5 years
- The research is disseminated in articles and chapters, and in some cases as books, mainly in acknowledged journals and publishing houses

- Oral presentations are given mainly at national and international conferences
- The "average" candidate has published the dissertation as a pdf.file with public access and written 4 peer reviewed and 2 other articles/chapters. Presented at 6-7 conferences and in a few other media.
- Most candidates obtain [or maintain] academic positions

Until 2009, the PhD completion rate was 100% [and only a few students have left the program since] - a fact that Tony was rightfully proud of. He explained it as an effect of the demanding as well as inspiring and supportive milieu, of which he was not only the head but also the heart. Also PhD students from programs in other countries have benefited from their visits to Aalborg. Tony was inclusive and welcomed guests.

The Danish Research Council of the Humanities [FKK] did not know the statistics presented here when the music therapy research milieu in 2007 was awarded the prize as "The most dynamic humanistic research milieu of the year." Tony decided that the prize [100.000 DKK] should be used to produce a DVD demonstrating and documenting music therapy in Denmark in theory and practice - as an evidence-based form of treatment. The DVD was published in 2010.

Tony's last triumph was a grant of 1.600.000 Euro to finance mobility stipends in music therapy. This meant the enrollment of 9 new PhD students in 2010. Tony's legacy will live on for many years.



Prof. Kirsten Drotner [Chair of the Danish Research Council of the Humanities] gives the council's prize for "The most dynamic research milieu 2007" to Professor Tony Wigram and Associate Professor Lars Ole Bonde.

Motivation: The prize is given "for having developed music therapy in Denmark to a broadly scoped, research based profession with a strong international reputation, and for having made a contribution to enhancing the perspectives of humanistic research by building a bridge between the humanities and health care science."

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Tony Wigram as Research Supervisor

By Cochavit Elefant, University of Haifa & Felicity Baker, University of Queensland

Anyone who has ever met Tony, even for just a few minutes, would easily be affected by 'Tonism,' his character, energy, sense of humor, his music, but most of all his enormous heart and love for people.

Tony was our PhD supervisor. He was a supervisor with a wealth of theoretical, research and musical knowledge. His enormous experience and passion for clinical work and belief that the basis of good research is good clinical work helped each one of us [clinicians at heart] to find our own research voices. He guided us closely through our research journey; during the ups and downs, but also provided us with ample space for growth and development. He listened and respected our experiences and knowledge, and this left us always with ownership of our research project.

The PhD training program at Aalborg University was a very serious one with a focus on clinical research. It exposed us to different perspectives and research methods brought to us by many international teachers. Tony never hesitated to surround himself with professionals and to share with them knowledge as well as the pleasures of life.

We'll describe below our typical morning during our PhD courses at Aalborg University.

Tony arrived at 7.30 at the Park hotel; ate breakfast while also giving his first supervision to one of the students. At 08.30 he drove quickly to the university, made copies of documents, entered the classroom and placed a sheet of paper on each desk. The students and teachers slowly entered the classroom and sat by their desks. Suddenly voices of laughter began to fill the room. This is how our day began, with jokes that Tony had prepared for us.

One of Tony's strength as a supervisor was that he could recognize potential – potential in prospective PhD candidates and potential in our proposed research ideas irrespective of the clinical research field, methodological approach, or philosophy of practice. Not only did he respect diversity, he also thrived on it and valued its role in the ongoing development of music therapy. He recognized candidates' potential, advocated for them during their application for the PhD program, and then nurtured and shaped them during the following years. Tony was dedicated to his students – phoning students for supervision session mornings, noons, and well into his evenings to accommodate the many time-zone differences among his truly international student cohort which spanned Australia, Asia, Middle East, Europe, Scandinavia, the UK and the USA. He was dedicated to quality supervision and seized any available opportunity for meeting his students. For example, on several occasions, he arranged to meet his students while he was at the airport. He never wasted a moment!

His research students were like his "other family." He shaped us as we grew from inexperienced young researchers to fully qualified PhD graduates, and, just like his

own children, he continued to mentor us as we moved on in our careers.

While Tony worked hard, he also knew how to “play,” and, more importantly, how to “cook.” He was a whiz in the kitchen cooking up several dishes for his PhD students at the semi-annual PhD course dinner he hosted in his apartment. After a full day’s supervision often finishing at 6pm followed by dinner with the group, he would go home and prepare the meal – sometimes until 2 or 3 am before arriving on time, and fully “present” for supervision at 7.30 am sharp the next day. He was whole-heartedly dedicated to excellence in supervision, but with an appropriate balance of relaxation and fun. In this way, he was also a role model for us.

We would like to end with a few words about his wife, Jenny and his three sons. ‘Behind a great man there is a great woman.’ Thank you, Jenny, for giving Tony the space to engage with us during our research studies. You always welcomed us into your home without reservation. We were also privileged to witness Robert, Michael and David develop and grow into amazing people. The entire Wigram family travelled with us throughout our PhD process.

Tony Wigram’s Contributions to the Assessment of Children with Autism and Multiple Disabilities.

By Ulla Holck, Aalborg University & Stine L. Jacobsen, PhD Student, Aalborg University

Assessment in music therapy was of great concern to Tony Wigram throughout his career, and he emphasised again and again the need for the development of rigorous and standardized assessment tools (Wigram, 1999; 2000; 2002; 2005; & 2007). His extensive clinical background and experience supported this focus, initially at Harperbury, a hospital for children, adolescent, and adults with developmental disabilities, and later at Harper House Children’s Service, a hospital department for difficult-to-diagnose children. Tony’s interaction with doctors, psychiatrists, psychologists, pediatrics, speech & language therapists, physiotherapist, and occupational therapists led to his precision in identifying the special needs of his clients and in specifying how music therapy treatment could address these needs.

Tony focused on clinical assessment throughout his career and was an advocate for including assessment as an academic discipline within music therapy. To that end, Tony provided a useful and clear overview of the varieties of music therapy assessments [fig. 1].

	Purposes	Function
A	Diagnostic assessment	To obtain evidence to support a diagnostic hypothesis
B	General assessment of client	To identify the general needs of the client from a holistic perspective and recommend relevant intervention
C	Assessment of music therapy intervention	To obtain evidence supporting the value of music therapy as an intervention
D	Assessment prior to treatment	To determine in the first two-three session a therapeutic intervention relevant to the client.
E	Assessment of effectiveness of treatment	To evaluate over time the effectiveness of music therapy

Fig. 1. Overview of the variety in music therapy assessment models [Wigram, et al. 2002, p. 247]

In both his clinical work and his writings, Tony used music as a nonverbal and social interplay with his clients, and his work at Harper House specially focused on the use of music therapy as a means of distinguishing children with Autism Spectrum Disorder [ASD] from other severe communication disabilities.

"From my experience, children with autism or Asperger's syndrome demonstrate their pathology in their music in a way that sets them apart from children with language disorders, who look autistic" [Wigram, 1999].

Tony believed that, when compared to standardized tests for intelligence and cognitive functioning, music therapy assessment allowed a more flexible approach to exploring the creative potential of the child, and for assessing areas of nonverbal communication and social engagement – areas where these children have some of their most profound difficulties [Wigram, 2005].

He further stated that evaluation and interpretation of both qualitative and quantitative data offered additional, relevant information besides social engagement. Analysis of musical improvisation could help identify, compare, interpret and reach conclusions about a child's personality, pathology, and presentation [Wigram, 2005, p. 537].

Wigram's method of music therapy assessment consisted of 1-3 sessions, in which he alternated approaches to observe the reactions of the child. His way of consciously, subtly and amusingly varying his improvisations with children to learn about their personalities and special needs really was his trademark method. He could go from playing in a

very structured manner to playing with slightly less structure and learn much from the child's reaction. He could imitate the child's expression and thereby invite the child to imitate him as well [Wigram, 1995; 1999]. All aspects of his assessment process were executed with humor, sensitivity and an enormous respect for the child. Tony's assessment method is vividly described both in text and video excerpts by the case example of Joel, a 7 year old boy with a possible diagnosis within the autistic spectrum [Wigram et al. 2002; Ridder et al. 2010].

In analyzing the child's musical improvisation, Tony's assessment was based on Bruscia's [1987] comprehensive Improvisational Assessment Profiles [IAP]. Out of the six profiles in the IAP, Tony applied two profiles; Autonomy and Variability, in assessing children on the autism spectrum. These profiles were particularly useful in distinguishing between children with Autism Spectrum Disabilities [ASD] and children with other severe communication disorders. The focus on assessing autonomy in the child's improvisation enabled a close look at interpersonal events, the readiness of the child to interact with others, and his or her turn-taking, sharing and behavior as a musical partner. The assessment of variability in the improvisation could illustrate the child's intrapersonal capacity, especially for creativity, whereby a rigid or repetitive way of playing could indicate a possible diagnosis on the autistic spectrum. In using these profiles and focusing on the frequency of specific musical events, Tony created a tool that was both applicable in clinical work as well as useful in research. He was knowledgeable of the procedures of Event Based Analysis [EBA] and provided clear and

structured guidelines and presentation formats [Wigram, 2007, p.218]. For clinical purposes he emphasised the importance of keeping data to a minimum and selecting profiles and improvisational material based on relevance and essentiality. He also stressed the need to consider the diagnostic questions, therapeutic relevance, and individual needs of the client [Wigram, 2007, p.216]. He suggested that the analysis of several music improvisations could provide sufficient recurring characteristics of the client to establish consistency of evidence [Wigram 2007, p. 225]. By using descriptive statistics, Tony believed that it was possible to qualitatively and quantitatively describe central tendencies in the client's play [Wigram, 2001].

Throughout his career as a music therapy clinician, supervisor, and researcher, assessment in all its forms remained important to Tony. In 2007, he and Thomas Wosch collected, edited and compared 20 well-established music therapy assessment and microanalysis methods [Wigram & Wosch, 2007]. He contributed to the field of music therapy assessment not only with a large amount of literature, reports, and papers, but also with his highly valued presentations and teaching in many parts of the world. Tony traveled much in order to fulfill his altruistic urge to help and guide music therapy students of many kinds.

In his last years, Wigram supervised several PhD studies concerning music therapy assessment of different populations, including voice assessment within a psychiatric setting, communication and social skills assessment within rehabilitation, and the assessment of parent-child interactions within a family care setting. Tony's knowledge, skills and

clinical experience together with his respectful, caring and supportive guiding and teaching are unique and irreplaceable. He has indeed inspired us to continue to place assessment high on the list of important topics in music therapy for the future...

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Tony Wigram: Bibliography 1992-2011

By Lars Ole Bonde, Aalborg University

The *British Journal of Music Therapy* 21[1] published a valuable bibliography and systematic overview of Tony Wigram's publications from 1983 onwards.

The bibliography published in *Voices* Nov. 2011 [www.voices.no] is long, even if it is limited to Tony's years as Associate/Full Professor of Music Therapy at Aalborg University [i.e., from 1992]. For the period, 1992-2011, the bibliography is more complete than the BJMT bibliography, because it is based on Tony's own records in the Aalborg University database, VBN. I have edited the list to correct errors and include missing entries plus papers that will be published over the next year. Tony's many conference papers and unpublished manuscripts are not included in the *Voices* bibliography, but they can be identified – like all the published papers – at www.vbn.aau.dk. Aalborg University Press plans an e-publication of selected keynotes and conference papers. You can contact me for more information on this on lobo@hum.aau.

Wigram, T, Pedersen I.N. & Bonde L.O [2002]. *A Comprehensive Guide to Music Therapy*. Jessica Kingsley Publishers: London

Wigram, T. & Wosch, T [2007]. *Microanalysis in Music Therapy: A Comparison of Different Models and Methods and their Application in Clinical Practice, Research and Teaching Music Therapy*. In Wosch & Wigram [ed], *Microanalysis in Music Therapy*. Jessica Kingsley Publishers: London.

dk. Tony was productive till the end of his life, and I will end this introduction with a list of forthcoming Wigram publications.

Wigram, T. [in press]. *Musical techniques and therapeutic methods to develop creative improvisation skills: the tools for of imaginative music making*. In Hargreaves, D., Miell, D., & MacDonald, R. [eds.], *Musical Imaginations: Multidisciplinary Perspectives on Creativity, Performance, and Perception*. Oxford University Press.

Wigram, T., & Gold, C. [in press]. *The religion of evidence-based practice: Helpful or harmful to health and well-being?* In R. MacDonald, G. Kreutz & L. Mitchell [Eds.], *Music, Health and Wellbeing*. Oxford, UK: Oxford University

Odell-Miller, H., & Wigram, T. [forthcoming]. *The Practice of Music Therapy for Adults with Mental Health Problems: The relationship between Diagnosis and Clinical Method with Specific Reference to Personality Disorder and Schizophrenia*.

Pedersen, I. N., & Wigram, T. [forthcoming]. *Counter transference experienced by music therapists in musical improvisation in adult psychiatry. A phenomenological study*. Submitted for publication.

Tony Wigram's Contributions to Research

By Christian Gold, GAMUT, Uni Health, Uni Research, Bergen, Norway

To provide a complete overview of Tony Wigram's research would be impossible in a brief article like this. Here I will merely outline – very subjectively – a few themes of his research that I feel were important.

To Publish or Perish (the "Aalborg Effect")

As a music therapist, Tony could be considered to have been a part of the "second generation," as he trained with one of the pioneers. As a music therapy researcher, he was a part of the "first generation" and will undoubtedly be remembered as one of the great pioneers. A complete – and impressively long – list of his publications is provided elsewhere in this issue [Bonde, 2011]. It is fitting that this list was compiled by one of his long-time colleagues at Aalborg University [AAU] because the largest share of his research activities was linked to his position there. Tony referred to the rise in the number of publications at AAU proudly as "the Aalborg Effect" (Wigram, 2007a, p. 49). In his typical self-ironic way, he described it as "the narcissistic and grandiose idea that all the people out there want to know what you do, think, theorise, practice," so that "writing becomes almost a compulsive exercise, a 'pathology'" [ibid.]. If it is true that an academic has to "publish or perish," Tony definitely chose the former.

Among the many books, book chapters, and journal articles he published, the five most cited as of the time this article was written¹ include two clinically-oriented books (Wigram, 2004; Wigram, Pedersen, & Bonde, 2002) and three meta-analyses providing evidence of music therapy's effects (Gold, Heldal, Dahle, & Wigram, 2005; Gold, Voracek, & Wigram, 2004; Gold, Wigram, & Elefant, 2006). He was a clinician with heart and soul as well as a relentless fighter for producing scientific evidence to support the value of music therapy, and I would say that his passion for the latter was founded in his passion for the former.

Evidence (and the Religion of It)

I had the honour of joining Tony as a co-author in one of his last publications (Wigram & Gold, in press), which was revised at a time when he was already seriously ill. For that book chapter, Tony chose the wise and provocative title: "The religion of evidence-based practice: Helpful or harmful to health and well-being?" As one who had been on the forefront of producing and disseminating evidence for many years, he was definitely in a position to be asking such questions. He was very aware that regardless of how much, or how good, scientific evidence music therapists were going to produce, there will always be some who will question its value. Furthermore, scientific evidence can never replace, but on the contrary has to build on, good clinical practice. Further, scientific evidence also needs enthusiastic people who carry the

¹ calculated using Harzing's Publish or Perish software, which is based on the Google Scholar database. Search date: 6 September, 2011

message into the political arena if it is to have an impact there. And lastly, the value of good clinical anecdotes in convincing policy-makers is unlikely to ever be replaced completely by numbers. In the book chapter, Tony both discussed the evidence that already exists, the influence it has had on relevant policy documents, and the frustration that can arise when policy-makers do not seem to listen. He concluded that evidence-based practice “can be a force for good” but should be “supported not only by rigorous research, but by clinical knowledge, wisdom and personal experience.”

Systematic reviews and meta-analysis are usually considered to be at the top of the “hierarchy of evidence,” and Tony’s top five cited publications include three of these. All three found positive and encouraging results for music therapy. The first, Gold, Wigram, & Voracek, 2004, provided a broad overview of the effects of music therapy for children and adolescents with mental health problems, and concluded that music therapy had a “medium to large positive effect ... on clinically relevant outcomes” (p. 1054). The second review, including only the most rigorous randomised controlled trials [RCTs], concluded that music therapy “helps people with schizophrenia to improve their global state and may also improve mental state and functioning if a sufficient number of music therapy sessions are provided” [Gold, Heldal, Dahle, & Wigram, p. 1]. The third review focused on children with autism spectrum disorders [ASD], one of Tony’s main areas of both practice and research [Gold, 2011a]. Also here, the encouraging results were that “music therapy may help children with autistic spectrum disorder

to improve their communicative skills” [Gold, Wigram, & Elefant, p. 1], again including only rigorous controlled trials.

However, a tension that also reflected Tony’s quest for both clinical wisdom and scientific rigour was found in all these reviews to some extent, and particularly in the autism review: Many of the included studies were “of limited applicability to clinical practice” [Gold, Wigram, & Elefant, p. 1]. Clinical improvisation, widely used by music therapists worldwide and promoted and developed enthusiastically by Tony in seminars and books [Wigram, 2004], was hardly ever used in the RCTs that met the methodological criteria for inclusion. One drawback of systematic reviews is that they have to rely on studies that were conducted in the past. Conversely, one of their strengths is that they highlight gaps. Although the studies included in the autism review were likely over-structured in the type of music therapy that was applied, Tony was also able to make something positive out of this: He noted that those studies did “illustrate the value of structure, which is generally an essential element for children with ASD,” and that music contains “rhythmic, melodic, harmonic and dynamic structure” which can be effective if “applied systematically and skilfully” [Gold, Wigram, & Elefant, p. 8]. Tony then went on to co-author the first RCT on improvisational music therapy for ASD [Kim, Wigram, & Gold, 2008, 2009].

Collaboration in Research

One thing that these examples illustrate is the need for collaboration, and Tony

was excellent in doing this. To produce the best research on the best clinical work, it is important that the best researchers and the best clinicians work together [or even better, good researchers who also understand clinical practice and vice versa]. In the past, music therapy research was often a “one-man show;” but as the discipline develops, this is unlikely to remain the most successful strategy. Tony’s publication list [Bonde, 2011] demonstrates collaboration with local and international colleagues, as well as PhD students and former PhD students, with a clear increase in such collaborative work over the years.

Another area where he collaborated with enthusiasm, versatility, and perseverance, was the Nordic Journal of Music Therapy [NJMT]. A fuller account of his contributions to NJMT is provided elsewhere [Gold, 2011b], but he helped the journal continuously since its beginning in 1992. Over the years he was active for the journal as Reviewer, Language Consultant, Section Editor, and Associate Editor. He was also Guest Editor for a special issue linked to the 6th Nordic Conference of Music Therapy in Aalborg [Wigram, 2010a, b]. Both the conference and the special issue were examples of how he used social networks [real ones, not the virtual ones that people associate with the term today!] to develop academic and scientific research in collaboration with many others.

On Having Fun with It

Hard working as Tony was, he was very aware of the need to have fun with the work and to celebrate the successes –

big ones as well as small ones. His friends will remember a phrase that he used to shout out: “What a triumph!” The occasion could be as small as a successful conference presentation or even a good and enjoyable dinner. “A cosy atmosphere” [Wigram, 2007b, p. 77] was important to him, and he was mindful that this was important for the success of his PhD students as well: “Above all, I believe that doctoral researchers need nurturing and support, and part of the success of the programme has relied on a milieu that is friendly, allowing, respectful, fun, interesting, supportive and caring.” [ibid.] His “morning jokes” and home-cooked meals [three kinds of chicken curry, “garlic bomb”, and other delicacies] at PhD courses, and the “robing ceremony” after PhD defences were legendary. He also brought the same sense of enjoyment into other arenas of research collaboration [such as NJMT]. But he could also be ironic about that. In one of my first PhD supervision meetings with him [12 years ago], I remember him saying: “I am not satisfied until a PhD student breaks down in tears.” I added: “tears of laughter,” to which he agreed.

As I wrote in my NJMT editorial [Gold, 2011b], Tony was always clear that the basis of good research is good clinical work, and the basis of that is being a good musician. Thus, his achievements as a researcher cannot be separated from those as a music therapist and as a musician. He will be sadly missed, but his legacy will continue to inspire musicians, clinicians and researchers alike.

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Professor Tony Wigram: Collaborator and Innovator

By Denise Grocke, University of Melbourne, Australia.

Professor Tony Wigram loved to be with people and to connect people together wherever and whenever possible. His outgoing, generous and fun-loving personality spearheaded many lasting collaborations within the field of music therapy. Tony was a member of the original group who developed plans for the World Federation of Music Therapy, initially in 1976 through to 1985 when the first document was signed in Genoa Italy at the 5th World Congress of Music Therapy. Tony was the Scientific Chair for the 7th World Congress in Vitoria Spain in 1993, when the Constitution and By-laws of WFMT came into effect. He then served as Chair of Government Relations of WFMT, and gathered important information about the status of music therapy in countries throughout the world. Subsequently he served as President of WFMT [1996-1999]. It was during his term as President that the WFMT truly became an international network. There were various commissions of the WFMT, and Tony's first suggestion on assuming Presidency was that each region of the world should be represented on each of the Commissions. In this first task, he doubled the size of the WFMT at its core, and in so doing expanded communication across the international group, gathering information on the essential features of music therapy prac-

tice worldwide. Further, he collaborated with Gianluigi di Franco [Chair of Publications] and Ismez, a publishing house in Italy, to produce regular newsletters for the WFMT. These were works of art with beautiful calligraphy and elaborate design, and the content kept the world informed of music therapy events, particularly conferences.

Tony was also an instigator of the European Music Therapy Committee [EMTC], which was established after the European Union was formed, with the intention of creating guidelines for the recognition of music therapy through European countries. Tony was passionate about the EMTC, and served as inaugural President from 1989-1998 [see also the tribute written by Monika Nocker and Gro Trondalen].

In 1992 Tony, Hanne-Mette Kortegaard and I embarked on a collaborative project for the WFMT to identify where music therapy courses were situated in the world, and to find out basic information about the length of the course, what content was being taught, philosophical orientation, and how clinical training was conducted. Our questionnaire, dubbed the WEK questionnaire [Wigram-Erdonmez-Kortegard], was sent to 41 educational institutions across Europe, UK, North and South America, Canada, China, Japan, Australia and New Zealand, and the results of the survey were compiled into a report for the WFMT, published in 1996. At that time Tony was serving on both WFMT and EMTC, and he was instrumental in the survey's being disseminated widely.

In recent years Tony had turned his attention to research collaborations, and in 2002 the first collaboration was formed between the University of Melbourne, Aalborg University, Denmark, and the University of Witten-Herdecke, Germany, with Professor David Aldridge. Tony had already established the “Aalborg” model for research meetings, where postgraduate research students presented a progress report of their research project and received feedback from international experts. This model was an empowering one for students and provided incentive to present new material. With the first collaboration in place, regular teacher exchanges took place, particularly between Melbourne and Aalborg, as Melbourne too accepted the Aalborg model.

In 2007, more collaborations with the University of Melbourne and Aalborg University were added: Temple University [USA], University of Queensland, and the Grieg Academy at Bergen University [GAMUT]. In 2008 Anglia-Ruskin University in Cambridge, UK, the Norwegian Academy of Music in Oslo, University of Jyväskylä in Finland, and Leminsinstitut in Belgium were added to the Consortium. Tony set out three areas of work for the collaborations:

1. International benchmarking for postgraduate research students proposals, ethical procedures, supervision and examination of theses. He initiated two extended courses on PhD supervision, held in Denmark for approximately 20 music therapy academics. These courses enabled in-depth discussion of issues about supervising PhD students in

music therapy research, including the structure and design of studies, methods of analysis and standards in writing a thesis. Aspects of effective supervision were covered, with a view to establishing benchmarked standards for initial and elaborate proposals, confirmation of candidature, and the process and standards of examination.

2. Collaborative Research Projects. It was the intention that the Consortium would work together to develop multi-site international trials, where one university would principally develop the study, and others interested would apply to granting bodies to run the study in their own country. An example of this was the Resource-Oriented Psychiatry study, developed at Bergen, that included sites in Norway, Austria and Australia.
3. Research teaching and supervision. The “Aalborg Model” for research-intensive seminars has been adopted by many of the universities in the Consortium, and it is common to have supervisors from several universities on PhD panels.

Tony visited the University of Melbourne every year from 1996–2010, in dual capacity as visiting teacher and also as research advisor. Over that period, he influenced 36 studies of Master’s degree and PhD students. What was remarkable was his ability to consult on all studies from infants to palliative care, from quantitative to qualitative, and mixed methodologies.

He exemplified a generosity of spirit that enabled the field of music therapy to grow internationally; he facilitated

people coming together to be connected and engaged in discussion. He brought humour, intelligence and knowledge to our meetings. He also had remarkable foresight and could see an opportunity for collaboration and development long before others, and would act immediately to galvanise energy for a new idea. These networks continue to work effectively today, with focussed energy and clear direction thanks to the solid groundwork built by our esteemed colleague, Professor Dr Tony Wigram.



Tony Wigram: An Appreciation from the Last EMTC Past President to the First Past President

*By Jos De Backer, EMTC past president
(2001 – 2010)*

A few times in a lifetime you meet someone who changes your life. Professionally for me this person was Tony Wigram. I met Tony for the first time in Groesbeek, Holland in 1992 where we prepared for the European Conference in Cambridge, England. My first experience of Tony was that he was a music therapist with a wonderful personality – an emotionally open man who was full of clear ideas. During this meeting he was already dreaming of creating a Network for Music Therapists in Europe, by bringing music therapists together to broaden all our knowledge. Tony always had vision towards the future, and significantly this dreaming about the EMTC was in a period where internet was not yet born – it was an idea ahead of its time.

This was the image of Tony that I had: a man who was very dynamic, happy and full of ideas about bringing people together – bringing people into dialogue by creating possibilities and projects enabling collaboration.

Besides his professional work in London [where he developed new treatments in

music therapy for autism and disabled people] he also developed the international research program in Aalborg. The EMTC was one of his most important political projects. This he started with some friends and colleagues and it was in Cambridge that we had the first meeting of the EMTC – in a café. I can still see him full of excitement about the idea that we were creating something new.

In the first period of the EMTC, when Tony was the President, I remember very well how he organised things successfully and kept the connection between different countries by writing letters to Country Representatives. How things have changed today with the internet making these links so much easier. At the same time as creating this European network, Tony was also maintaining a sense of a European identity by beginning to travel to several countries, teaching and giving workshop, and of course to meet also with EMTC Country Representatives.

As long as I knew him, Tony was always there to coordinate and to improve the scientific quality of European committees for various conferences. As with other people who instigate ideas with such enthusiasm, I would describe Tony's wonderful energy as his personal way of working as a 'functional manic'. An example of this was for the European conference in Leuven, where we worked for two days and one night without sleeping in order to create and finalise the Belgian scientific programme. The simple but essential fact that also made this possible was that Tony knew everyone. He was full of passion and curiosity to see how music therapists improved their knowledge and specialisation. Tony

frequently made often very important decisions and all the scientific committee members at European conferences learnt a lot from him.

Tony always was open to help the later EMTC Presidents [Gianluigi and myself] and gave us advice about how to develop the music therapy strategically in Europe. He had a more worldwide vision about the culture and methods in music therapy than anyone else I know – he really was the first World Wide Web [WWW] for Music Therapy. He knew so many people and was networking and offering his knowledge and connections to everyone in order to develop dialogue around the world. I was always very impressed about this and so thankful to him for it.

Tony was also critical about some developments in music therapy and we discussed this a lot when we were sitting in my garden during his breaks in travels between London and Aalborg. Of course, as friends, we shared other things together of a more personal nature and this was always part of our exchanges. I also remember a very long and dynamic evening developing and discussing the minimal standards for the European Music Therapy Register [EMTR] and interrupting this by improvising together at the piano, or cycling and walking. These minimal standards of the European Register are the cornerstone of the identity of the quality of music therapy and Tony believed very much in this and was proud that two years ago the EMTC made this register operational.

Thanks to Tony the EMTC started to grow but there were also difficult times, and the most painful experience in his EMTC

history was the death of Gianluigi Di Franco. It is strange that we lost the two past EMTC Presidents too early, for they both had much more to contribute to our profession; as well as the personal loss to so many of us, there is also the professional loss to music therapy.

I took on the important job of EMTC President together with Dr. Julie Sutton and Dr. Monika Nöcker-Ribaupierre, because the EMTC needed to continue to move forward from the new structure developed by Tony and Gianluigi. In one of the last visits I made to Tony he told me that he was very proud of the EMTC and was hoping that the new generation will safeguard the quality of European music therapy and to continue developing the dialogue between music therapists in different countries.

Thank you so much Tony for coming into the life of so many people and especially into my life. I will never forget you!

Tony Wigram's Role in the European Music Therapy Confederation (EMTC)

By Monika Nöcker-Ribaupierre, Freies Musikzentrum Munich & Gro Trondalen, Norwegian Academy of Music

Professor Dr. Tony Wigram was the heart of and a very important impetus for the development of music therapy in Europe as well as the creation of the European Music Therapy Committee (EMTC). From the initial traces of the EMTC, he was a core figure, and the first President of the EMTC, a position he held until 1998.

The EMTC was formed in July 1989 through the efforts of Tony Wigram (United Kingdom/Denmark), Gianluigi di Franco (Italy), Helen Odell-Miller (United Kingdom) and Patxi del Campo (Spain). Its main aim was to create a network of music therapists that would link the different countries of Europe. This network also served as a means for exchanging and discussing information related to academic training, research and clinical practice in music therapy and developing professional identity in Music Therapy.

During its first years, the EMTC grew rapidly. As then, today's European Music Therapy Confederation's members are professional music therapy associations working actively to promote the development of professional practice in Europe, and to foster exchange and collaboration among its member countries. Since its beginning, one of the goals has

been to promote regular meetings and to organize European conferences every three years. These conferences have been focused on clinical, professional and research topics and have been held in Cambridge, UK [1989], Vittoria-Gasteiz, Spain [1992]; Aalborg, Denmark [1995]; Leuven, Belgium [1998]; Naples, Italy [2001]; Jyväskylä, Finland [2004]; Eindhoven, Netherlands [2007] and Cadiz, Spain [2010]. The next conference will be held in Oslo/Norway in 2013.

The EMTC has also created smaller working groups focused on specific topics, such as supervision, ethics, research, and the development of a European registration procedure.

In May 2004, the EMTC achieved official assembly status at the European Union (EU) level in Brussels, as a non-profit, international, professional organization according to Belgian Law. This new EMTC has a Constitution, Bylaws and a Code of Ethics. It is managed by an administrative infrastructure consisting of a Core Board (President and 2 Vice-Presidents: General Secretary and Treasurer), and a Board (3 regional country coordinators). Each member country has a single representative; this representative is elected by the national EMTC member associations within each country. The country representative is responsible to his national associations. Today, membership includes music therapy associations from all 25 EU countries, from EU candidate countries in Eastern and Central Europe and also from countries outside EU with special national agreements with the EU.

While the theoretical bases, methods and concepts of music therapy training are different within each country, the

overall purpose of the EMTC is still to nurture mutual respect, understanding and exchange. Consistency of a high professional level of practice is vital, in a way that maintains an individuality of approach, philosophy and specialization. This is essential for the further development of the profession around the world. Moreover, a priority of the EMTC has been to create standards, including an ethical code for music therapists, standards for training courses, supervision and self-experience, and requirements for a European Music Therapy Register.

At this moment there are 60 official training courses throughout Europe on BA and MA levels, as this accredited standard is required by the EC, following the Bologna Treaty. An ongoing priority is the establishment of the European Music Therapy Register (EMTR), a development that is linked to the standards of university-level qualifications. The EMTR will ultimately support the various national efforts towards achieving official government recognition of music therapy.

Tony Wigram was the heart of and a key figure in the development of music therapy in Europe. As the EMTC's first coordinator and first president, his contribution to the creation and development of EMTC has been tremendous. He organized and structured all the meetings until his WFMT presidency began in 1996; including the election of the new president in 1998 at the Leuven-conference. Tony wrote all the organizing emails in between and the minutes from the meetings. In 1994, for the pre-conference in Capri, he formulated EMTC's first working paper which contained the first constitution: the purpose of the new confede-

ration, the responsibilities for membership and the tasks of the three regional coordinators. Tony also formulated the goals for the sub-committees on education and training, on research and on registration and ethics, and he stated that "the official language of the EMTC will be English." With this paper, Tony Wigram set the first boundaries and goals for the EMTC, i.e., the basis for the development of the EMTC throughout Europe. After being elected the president of the WFMT, Tony always supported the President who followed him (Gianluigi di Franco and Jos De Backer) and strengthened their position. Tony was indeed a trailblazer and influential leader – his ability to communicate and persuade was exceptional. Slowly he decreased his tremendous efforts for EMTC in favour of his new task at Aalborg University – establishment of a European and worldwide platform for a higher academic level of training: the PhD in Music Therapy.

For his work, the EMTC honored Tony Wigram in 2004 with the first EMTC Award. He has inspired students and professionals all over the world through his contribution. His energy, great knowledge and enthusiastic ways of working within the EMTC were highly esteemed and invaluable.

Tony Wigram had a wonderful sensibility and wisdom that helped people to come forward and be heard. At the same time, he was a brilliant musician, and his humor was legendary.

We are deeply thankful for Tony's immense contribution to music therapy in Europe. He is and will continue to be remembered with deep respect and love. We will miss him.

Memories of Tony Wigram-His Early Career

By Helen Odell-Miller, Anglia Ruskin University

Introduction

Tony was employed as a part-time Professor in Music Therapy at Anglia Ruskin University at the time of his death. Initially as a visiting professor and lecturer he had undertaken various roles since the inception of the MA Music Therapy in 1994. He contributed to the established Music and Health Research Centre at Anglia Ruskin University, and led the formation of an International Music Therapy Research Consortium which our university joined. I had the privilege of working with Tony throughout his career, and in this article will focus mainly on his early years as a music therapist.

'Wigram' was one of the most prolific writers in current music therapy publications, and wrote or edited fourteen books on music therapy, authored more than fifty articles in peer reviewed journals, and over seventy chapters in books. His research interests included the physiological effect of sound and music; assessment and diagnosis of Autism and communication disorder; Rett Syndrome; methods of training and advanced level training in music therapy; and the documentation of methods and techniques in clinical practice in music therapy

Tony's affiliations, board memberships, and lectureships worldwide are extensive, and his publications span three decades. I hope to capture the essence of what he achieved in the early years, and how he managed to contribute so much.

Early clinical work and training

In addition to his phenomenal energy and outstanding musical skills, as a pianist and viola player, Tony was described by our head of department recently as "a brilliant academic, a generous and supportive colleague, and an inspiring man." His personal generosity included attentiveness to other people, and in particular, encouraging students, for example, to push boundaries. Tony had a wonderful sense of humour. He managed to outdo the university's health and safety policy and secreted a fridge unchecked by the authorities into the office, so that he could keep favourite food at work, and share olives [fresh from his most recent trip] and chocolate with colleagues. Nearly 40 years ago, similar characteristics were witnessed by all who encountered him.

I was lucky enough to meet Tony in 1972 before either of us became music therapists, when we played in The Apollo Symphony Orchestra. After studying music at Bristol University, Tony trained as a music therapist at The Guildhall School of Music and Drama in Pickett with Juliette Alvin and Maggie Pickett. I trained two years after Tony, and he generously took time to come to my home in North London to tell me about the course; he arrived characteristically on his motorbike. He enthusiastically described Juliette Alvin's improvisation classes,

including her phenomenal drive and musicality as a 'cellist, Alfred Nieman's free improvisation classes, and movement classes [which apparently occasionally took place in the dark]!

After qualifying as a music therapist, Tony soon became a leader of the music therapy profession in the UK, pioneering and developing music therapy treatment for adults and children with learning disabilities. He demonstrated musicality and warmth in his relationships with the adults and children who participated in his sessions. Working with him was informative, creative, and fun, despite the often difficult settings experienced by staff and residents.

As a student, I was sent by Juliette Alvin on a placement with Tony as clinical supervisor. This involved working at Harperbury Hospital, then a large residential Victorian setting for adults and children, and also in Cambridge where together, during my placement, we set up a full-time music therapy service at The Ida Darwin Hospital, a more modern environment for adults and children with learning disabilities. I thank Tony for his pioneering work which enabled me to take things forward in that post in Cambridge, after qualifying in 1977.

Tony taught me a great deal about the composition of song and improvisation in groups. Above all he had a phenomenal ability to connect even with the most withdrawn, behaviourally challenged people; I learned very early on about getting right inside the personality and character of the person, musically picking up emotional nuance, and never to be afraid of working in depth. This learning

was greatly facilitated by the working environment Tony created outside the music therapy sessions. He sang songs along the corridors in a French accent, fondly impersonating Juliette Alvin whilst transporting instruments. There were also early morning ritual stops at the shop on the way to Cambridge to buy cheese and chocolate biscuits. Tony offered food regularly to ward staff, and I learned early on that working in the multi-disciplinary team in these settings was central to the success of treatment for residents. One of his very first academic conference papers in the field was 'Noise in the institution' which he presented in 1983 at Hertfordshire College of Art and Design. The paper stemmed from his passionate belief that the environment in institutions was often overwhelming for residents. He campaigned for staff to consider the unhelpful effects of loud background music which may also have no meaning for the people living on a particular ward.

Early Political and Professional Influences

Tony's drive in those early days was also apparent in the political development of the profession of music therapy. During my training year at The Guildhall School of Music, I attended meetings of The British Society for Music Therapy (BSMT) and the then newly formed Association of Professional Music Therapists (APMT). I witnessed Angela Fenwick, the first chair of the APMT, and Tony who succeeded her as chair in 1980, skilfully setting up this new organisation. Focussing upon the professional interests of qualified music therapists and their services, the evolution of the APMT provoked debates and ar-

guments. Juliette Alvin and Sybil Beresford- Peirse 'accused' Tony of being a trade unionist. Not all could see the merits of proper pay and conditions for music therapists out of concern that this might damage the quality of the therapy work. Embedded within and arising from this process was Tony's drive to set up proper mechanisms for assessment, treatment and research. Later evidence of this is reflected throughout his publications. [Sutton, J. 2011].

To 'become' a profession in the UK, we first had to set down basic elements of music therapy training. I will never forget a meeting at The Guildhall School of Music and Drama, led and organised by Tony in 1980, when he, Leslie Bunt and I met with the three UK music therapy course heads, Juliette Alvin, Sybil Beresford -Peirse and Elaine Streeter to draw up and agree upon the components of basic training for a music therapist. In his usual way, Tony forcefully but calmly set down each heading, facilitated discussion, and listened. This resulted in a document, similar to current expanded documents, clarifying core elements of music therapy training. Subsequently, together with Professor Diane Waller, Tony continued leading us in the initial negotiations that culminated in the setting up of a career structure for art and music therapists in the National Health Service [NHS] through the Whitley Council in 1982. Later he contributed to the initial processes that resulted in the legal registration of music therapists under the Council for Professions Supplementary to Medicine [CPSM] in 1997.

At the end of his career, he was honoured by the organizations so important in

his early career. Despite his illness, Tony was able to appreciate three special UK honours even during the last few weeks of his life, and many more from around the world. These included an award from The Guildhall School of Music, where he trained and was a guest lecturer, a Vice Chancellor's Award from Anglia Ruskin University, for outstanding international contributions to research, and a similarly titled award from the British Association of Music Therapy for outstanding achievements to music therapy research. His work will be a legacy that future generations of music therapists will learn from.

Reference

Sutton, J [2011] 'A dialogue with Tony Wigram: considering music therapy and music therapy research in a changing world' BJMT, 25 [1] 8-31.

Tony Wigram – the Early Years. Interview with Tony Wigram January 12th, 2011.

Interviewers: Lars Ole Bonde [LO] & Inge Nygaard [IN] – with comments from Jenny Wigram [JW]

Abstract

The interview took place in Tony Wigram's home in St. Albans the day after he returned from Cambridge where he had participated in the annual seminar of the International Consortium of Nine Music Therapy Research Universities. This was more than three months after he was diagnosed with a brain tumour. The themes were Tony Wigram's clinical work at Harperbury Hospital and at Harper House in the 1970's and 80's, his interest in developing systematic music therapy assessment, and his engagement in political and organisational work within the profession of music therapy.

TONY WIGRAM [13.8.1953-24.6.2011]
Trained as music therapist with Juliette Alvin at the Guildhall Post-Graduate Course in Music Therapy.

Head music therapist at Harperbury Hospital and Harper House Children's Service. Associate professor in music therapy at Aalborg University [DK] 1992, ordinary professor from 1998. PhD in psychology from St George's Medical School, London University on a study of vibroacoustic therapy. His special clinical areas were autism spectrum dis-

orders, Rett's syndrome, and the physiological effects of sound and music. Head of the Post-Graduate Research Training program at Aalborg University from 1997. Visiting Lecturer at Anglia Ruskin 1994-2005; Professor 2006-11; Principal Research Fellow at the University of Melbourne 1996-2010. Chairman of the European Music Therapy Confederation 1989-96 and the World Federation of Music Therapy 1996-99. Chair of the International Consortium of Nine Music Therapy Research Universities from 2008. Associate editor of the Nordic Journal of Music Therapy. Major publications: *The Art and Science of Music Therapy* [1995], *Music, Vibration and Health* [1997], *Clinical Applications of Music Therapy in Developmental Disability, Paediatrics, Neurology and Psychiatry* [1999], *A Comprehensive Guide to Music Therapy* [2002], *Improvisation* [2004], *Songwriting* [2005], *Receptive Methods in Music Therapy* [2007], *Microanalysis* [2007].

BUILDING A MUSIC THERAPY SERVICE IN A LARGE HOSPITAL

LO: Can you tell us about the ideas that guided your work when you started as a music therapist at Harperbury Hospital?

TW: I found that when I was starting the work there was very little guidance on how you actually did the work. It was all intuitive. I felt more comfortable with some sort of structure, and it also felt more comfortable to me that other people who watched me working as a music therapist, could understand what that work was about. Because if you worked in a ward or day centre in Harperbury, people

didn't understand, they just saw someone playing music, or someone trying to encourage the children and adolescents to make sounds or play music. But they didn't know what the music making was about, so I found a need to give it some sort of direction. That was important both for the clients and for the staff.

LO: How did you get there in the first place? Why did they want a music therapist?

TW: In Harperbury, there was an inspired psychiatrist, his name was Derek Ricks. He ran a department for children, and he watched my work and thought this was a great way to engage with the children there. That was the main motivation. He couldn't believe that the children were responding so well, that they were playing and using their hands and interacting with you, and you know, he was impressed by that. He wasn't interested in doing some sort of behavioral intervention. He was more interested in the humanistic experience of working with these children and these adults and adolescents. And the interesting thing about Harperbury was that it included people ranging from ages 12 to 70, I mean it was about that age range.

I started working in the children's area. Derek Ricks was responsible for the children's wards. That's where he started his work, and where the music therapy started as well, so I got going with the children's wards first. And it wasn't assessment. The assessment work developed later under people like Barbara Kugler. In some ways, that's where music therapy began to assume some importance. Because when we started to build an assessment protocol, then people started being interested in; "What are

you trying to find out?; How do you evaluate him?; and so on." Harper House was the inspiration of that really, I think. It was interesting anyway, also because the two so-called children's wards contained a lot of adults. And at this time of my career, there was almost no information to support the value of music therapy with adults. It was all about children. And of course when you look at - just taking a side step here - when you look at what was going on at the Nordoff-Robbins Centre in London, they were much more interested in children, not so much with adults. It was a question really, that there was a priority on working with children. But of course, as soon as I started working with the older children on those wards, the nursing staff working with adolescents said: "Hang on, we need to have some of this for our populations as well, not just for children. What about the adolescents and adults?" So I got sidetracked into working with these populations. And of course that was very successful because some of the people on the wards, the staff on the wards were looking and saying: "Hang on, these adolescents and these adults are responding just as well". They were very impressed; they could see the adult patients responding to this intervention very, very well. You have to remember at this time, in the 80's I was working on wards where they got almost nothing.

JW: A lot of children went into that sort of hospital in the 50's and 60's, didn't they? Because parents were told: "Oh, just put them in the hospital." And they were very institutionalised.

TW: Yes, but the staff were looking at this and saying: "Hang on, I can see these

young adults responding well to this intervention." And they were surprised actually, because there was such a good response; excitement, enthusiasm, alertness, attention, awareness of what was going on, engagement with the staff, engagement with the other clients.

LO: Did you use video already at that time?

TW: Mmmh, I bought one of those big VHS cameras, you know. They're very heavy, but actually they produce very good quality material. I would actually take examples of the clients working with me and show it at the case conferences. Now that might seem totally inappropriate to you, but I had the lead to let the clients' families or carers see what could be done with a particular child. And you couldn't do it unless you actually showed them examples of what could be done. So when I went to case conferences on the ward, I would take along my video camera and say: "I would like to show you all an example of Joe as he was playing this morning, and I would show them that. And they were looking at it thinking: "Wow, this man can interact." And it was a simple thing: "he can interact." So I did that and I would take it on the wards as well, and I would show little things when I was on the wards, so that they could actually see the clients. Because I didn't think that half of them really believed it was going on [laughter]. They didn't actually believe that these people could interact and they said that they're too handicapped. But when they saw them interacting, it was a revelation to some of them, and I would of course show it to the staff as well. I would organise it so that we could have a session where other staff were joining with it

and starting to realise what was going on with the clients, and that they could engage with the clients as well. So I didn't see any ethical problem with this actually, because I was helping these clients and the staff to get together. That was what it was all about, in those days in the 70's and 80's at Harperbury. I wanted there to be co-therapy sessions where the clients could actually engage. [Editor's note: the videos were shown to parents and staff members involved with the clients. Also, at that time, consent forms for videotaping were not yet required].

IN: Yeah, I mean Nordoff & Robbins did also videotape everything at that time.

LO: What kind of language did you use to explain to the staff what was going on?

TW: Well, that's a good question. I would try to take the easiest way of explaining what interpersonal interaction was about, I mean social awareness, social intimacy, social sympathy. I mean all the things where you think: "Okay, what's really happening here? Is it about friendship? Is it about fun? Is it about enjoyment?" I remember one case meeting at Harperbury, actually with Mary Priestley. We had little seminars when Mary Priestley was there, and I remember one where Mary was looking at what I was doing and I had showed video of it, and I got the sense that she was thinking: "This isn't real therapy" [laughter] "This is people having fun - this is Tony Wigram having fun with playing songs from the shows." I mean literally playing - I played a lot of different things, songs from the shows and songs that people knew. She actually said it during the feedback after, and I said: "No, sorry, but this is real therapy. This is about

how you use any type of music to establish something that clients would know. And if it's a song they know or a melody they know or a rhythmic pattern that they know, what's wrong with that? That's also therapeutic."

LO: Did Juliette Alvin encourage you to think that way?

TW: Yes, when I trained with Juliette Alvin, I was on placement with her at Marlborough Road in London, where there was an autistic unit. She said: "You need to remember Tony, you've got to offer them structure. You've got to offer them something they can hear and work with." And I think even though she had a psychodynamic orientation, when she was working with learning disability children, she didn't push that argument too much, because at Marlborough Road we did lots of playing with simple structures and melodies and rhythmic patterns. It is actually about how you engage clients using good tunes that they know, and using feelings.

IN: I don't think Mary Priestley had any experiences with learning disabilities at all. It was not her business.

TW: No, but there is room for everything. I thought this was working very well. I became quite a character in the hospital, everybody knew me. I got lots and lots of instruments. I had a very big old wheelchair, a hospital wheelchair, that I put wood around and a frame around, and I packed all my maracas and all the instruments I used, and I dragged it around the hospital. And I would set up a schedule to visit wards, lots of wards and I would have aims for my work. I had them all set out - what I was trying to do - so that the staff

understood; working on attention with this client, working on physical mobility skills with this client, actually being able to use the instruments and handle them. And I trained a lot of staff on how to do this as well. When I was working on a ward I would say: "Right Jenny and Mary. I want you to know what to do, so I'm going to explain it to you," because the worst thing for clients, for staff, is if they don't know what their role is. That's a really important thing. So I taught them and I encouraged them, and I said: "Well, you don't have to do anything you don't want to do" that's the first thing. "But I'd love you to join in with this and to enjoy it." So I used them as co-workers, co-therapists, you see, and told them what I wanted them to do. And I always said: "The most important thing we need to work on is that you need to let the clients do what they can do and you have to become their assistant, not forcing them to do what you want." So, you know, I used to watch them very carefully to support the clients and to do little, you know, nice little musical interactive things using all their musical skills to try and encourage the clients to play and to be able to hear what they were playing. But I'd also play tunes that the staff knew, so that they could feel that they could join in with something that they would enjoy doing, that they played a tune that they liked - if they played for example: "This is the day the Lord has made" or something that they recognised. And I think that is one of the roles that the music therapist can offer to support what the client does. Not just with free improvisation, but also with well-known melodies, especially in that situation. If I'd do too much free improvisation, I don't think either the clients or the staff would have been able to make sense of it, you see. I don't regret having

to use all the resources of music as well as the well-known repertoire.

LO: Haven't you always done that?

TW: I think I have always done that, you know, yeah.

LO: Also with the students in Aalborg?

TW: Oh yeah, yes [laughter].

LO: I think that bringing in the main instruments of people into their work was something new actually. In Aalborg up to 2000, we demanded that the students used mainly voice and piano, and many of them almost forgot to use their main instruments. You really brought that back on track.

TW: Now that was an inspiration from Juliette Alvin again, because she said: "Your main instrument, your main voice of your music is the instrument you're most able to use." And of course it is interesting at Anglia Ruskin University that Helen Odell-Miller has brought this back in again, and I strongly supported this. There is so much emphasis on improvisation, but lots of students at Anglia Ruskin have got very good instrument skills that they can use, and they want to use. And so Helen has always ensured that they used their main instruments and accepted them by the instrument they were most able with. This is of course the thing with Juliette Alvin because her attitude about this was that the instrument you have the most skills on is the instrument - that your main voice is the one you are most able to communicate with. I don't know, maybe you think differently on this?

LO: Well, we had this big discussion, when we had to stop the individual solo training in Aalborg for economical reasons. What will we do now? I think you amazed some of us by saying: "It doesn't have to be the piano, we can let go of the piano as the only instrument. They must use the instruments they can actually play on."

TW: Yes, yes. And I think that people should be aware, that there is a value in harmony instruments, in instruments they can feel confident with. Of course they need to use the instruments they have the most confidence with. That's the best.

LO: Did you work with groups also?

TW: All the time. It was mainly group work. It was because I was also under pressure to see lots of clients. In my heyday I can say that I was seeing probably 300 clients a week in groups. There were 2000 clients in Harperbury. I had this big trolley I was talking about earlier. It was a big old wheelchair, a big trolley wheelchair, and I had fitted it with wooden sides and I had it packed with lots of different instruments - some ethnic percussion, cymbals, glockenspiels, blowing instruments. The trolley was packed with them, and people could hear me coming down the road [laughter]. And they said: "Here comes Tony," and when they saw me coming down the road in the ward, they would get all the clients in that ward into the dayroom, and I'd arrive on the ward to find about 30 clients or 40 clients waiting for me. And I kept saying to them: "I can't cope with quite so many clients in one session." But in fact in a lot of cases they all started joining in really enthusiastically, staff and patients, and it became quite

an interesting session. But it meant I had to sometimes say: "I want less, because I can't give them individual attention if there are 30 clients in this room." But it was a great time, and the clients were often very responsive in large groups. The more noise there was going sometimes, the more excitement there was going, the more you saw the smiles, the more you saw the interest and the enthusiasm, and the physical responsiveness.

LO: I guess there wasn't much more they could do together, was there?

TW: No, very little. And it was up to people to give them this enthusiasm. You had to give them something. And I think that's a very big difference about the way I was working at Harperbury and, you know, the more psychoanalytic therapists. I'm not saying that what the psychoanalytic therapists were doing was wrong. They were going at it from a different perspective, but I was aware that when I was trying to promote their enthusiasm for making music and creating music, sometimes the more clients there were, the better it went, because they got more excited. And of course large groups became very popular at Christmas and at times when they could all get together and play together, and some of the staff were also very enthusiastic about large groups, because it meant that they felt they were involved in it, that they were engaged in it as well.

LO: So you were the Pied Piper?

TW: Well almost, yeah. I suppose I ended up playing music that they would recognise, and the staff would engage with it, as well as clients, so you had to use those

sorts of inspirations for them. But it worked, that's what I can say, it worked, yeah.

IN: When did you get your first colleague there?

TW: My first colleague there was a lady called Diana Whitelake, and she came with Louise Ridley. She was a great colleague, really a wonderful therapist, working with clients. So Louise Ridley was a classic - now she's a vicar, but she was very able to work with people. I also had one who was rather psychoanalytic, but she didn't last very long [laughter]. I'll tell you a funny story about another assistant. Soon after she started, she asked to have an interview with me and she said: "I really can't work any longer here, with the clients, you've got." And I said: "Why not?" And she said: "Because they're not able to do music therapy." I said: "Why not?" and she said: "Because they're not good enough to respond to music therapy." And she asked to have more able clients, she said: "I need more able clients." I said: "Well actually, the clients I have got for you are the most multi-disabled ones, and you'll have to work with them or go away."

Another assistant wouldn't work with a group of clients, because she said that: "They're too disabled, they can't respond." I said: "Have you listened to what they're doing? Have you heard the noises they're making? The sounds they're making? How can you describe these people as not able enough? They're making nice noises - can you hear them?"

LO: Is that an attitude you have met now and then with music therapists?

TW: I think I met people who selected clients, who would selectively take ones who were giving them more back than they could get from other clients. And it wasn't unique to any particular training. Some people just wanted to have clients who were more responsive, which in a way is perfectly reasonable. I mean if you referred a client, and they have needs, then you have to make a decision. "How can I meet their needs," and if you can't meet their needs, then don't work in a place like Harperbury.

TW to LO: My tea has gone very cold, and isn't there any red wine left?

LO: Here's your red wine.

TW: Oh, good. [...] So I think that music therapy, the way I was working with it, had a lot to offer in many different genres that weren't at the time typical, but I was able to feel I could convince the staff that this therapy was fun, it was enjoyable, that the clients were responding to it. You could see the pleasure; you could see the interaction going on. Derek Ricks, who was my great guru there, was a phenomenal doctor and also very interested in music. In fact, I teased him sometimes, because he would come down to the ward, and as soon as he turned up, I would start playing some pieces by Mozart because he loved Mozart, and then he would come on the ward, and he would go: "What's that you're playing Tony?" And you know, I played - and he could see then how the clients would respond to Mozart. It was great for music therapy.

LO: You said in the beginning that it was very much about finding the right structure for the work. And I mean, it must

have been quite chaotic with all these big groups? So how did structure come into it?

TW: Okay, well the chaos was because people wanted me to see a lot of clients. I saw lots of clients, lots of children at the same time, and some of these clients were very handicapped, very intellectually disabled, and you needed to have several things in place: you needed to have staff who could help you, but you also needed to have enthusiasm for the energy level of the music, right? And you could see this beginning almost as soon as they started working, when I started playing some strong exciting tuneful music for example, they would respond to this. And the staff could see that. And the structure was built into that, because I would emphasise for example the first beats and strongly accentuate parts of the music, so that it became very clear when the clients could hear, and you'd actually see their bodies start to move, when they could hear both the tempo and the melody. It would stand out to the clients, and you could actually see the movements, the dancing and their eyes becoming bright and enthusiastic, and I think that's where I got the impression that they were able to immediately respond to music in this way. And the music therapist could facilitate that. We could help that happen for the clients.

LO: It was like an amplification of the musical elements.

TW: Yes, exactly. And you used the music to reinforce their responsiveness to the intervention; that was the most important thing. That they could hear you encourage in them musical responsiveness. That

was the critical factor I think. So that they could – you’d actually see them starting to, you know, engage with you and make movements that were related to it, which was where I got started with music and movement methods, which I was doing then with Lyn Weekes and other people. I began to get interested in the physical responsiveness of clients to music. So then I began to think: “Okay, now I need to work with people who can also work with that” and they were the physiotherapists. But I also worked a lot with educators. We had a hospital school at Harperbury, and I was working with people like Dave Hewitt who did the gentle teaching programme, did you ever hear of his work?

IN & LO: No.

TW: Okay, there was a track called gentle teaching, in the literature, or intensive interaction actually it’s now being called. And Dave Hewitt was a pioneer of this. And he was into engaging really closely with the clients at the tempo they could cope with. And he was working with very handicapped people, and he would gently draw out the things that they wanted to do. So we had this track going as well, but I actually encouraged him a lot, and he drew a lot of his ideas from some of the things I was doing from the gentle teaching, because they were so synchronous with music therapy. It was exactly what we had been doing. And he was in charge of a hospital school, but when he came he started looking at what we were doing, and he said: “What you’re doing, it makes perfect sense to me.” And he immediately started all the programmes at the hospital school, and immediately started them doing gentle teaching. It’s all in the literature: gentle teaching. And so, we got

a good team there that worked well with that, and I was very satisfied with that phase in the development. But it was still down to us, you know, using music was the foundation for engaging in the relationship with the clients, and I kept emphasizing to staff there, whether they were ordinary nursing staff or they were music therapists: “Your fundamental objective here is to build a musical relationship with the clients.” That came from Juliette Alvin. She was very good at that; picking up things that the client liked doing, and following up on them. So I think we made a nice development at Harperbury. That was actually the best of my work I think.

LO: It was fantastic. Do you still have some of the recordings?

TW: I compiled a tape of all sorts of my work at Harperbury including the famous one with the handicapped boy with the athetosis: Raymond. Raymond was his name, and I remember he was going out – he was driving his wheelchair and singing. And it was actually with Ann Sloboda. We were doing a film for the BBC actually, and we did several films for the BBC. That was another thing I did. BBC and ITV material. They came along to film “A day in the life of Tony Wigram” for one of those five-minute things they did for BBC. That was in the 70’s or in the 80’s, because when I started making the films on Vi-boacoustics and those things, then they all piled in, and we got the BBC and then we got ITV, and many different programmes would come in and make films of us working. And some of it was sometimes stressful – I remember one producer who wanted us to do the same excerpt ten times [laughter]. And I said to him: “Listen,

this is spontaneous improvisation, and I can’t reproduce the same thing ten times, because the clients are getting bored with it actually, and bored with you.” But I could remember that some of the people doing this were actually quite good doing this. Gosh, you could really look into my history and see a lot of interesting things there. It was actually one of the things it was good to do. I mean I did that deliberately. I had to get special permission from the hospital, the ethics people and all the rest of it. But I argued strongly, and I don’t know if all my co-therapists believed it was a good idea, because some of them felt that the therapist’s work is private to the client. But I think I argued successfully that this was actually working okay, and it was bounded and it wasn’t dangerous. I said: “I’m sure that the clients actually enjoy the therapy sessions enough to want other people to watch how they are enjoying it. And you can understand that if they enjoy it well enough, then it will become something that other people will say ‘We need to do more of that.’ ‘We need to see these clients have the opportunity to access these therapies more.’” Which was what happened, in some ways – I don’t know what you think, but of course there could be people who said: “This is bad, because it’s not bounded; these people are being exploited.” But I didn’t believe that. Not for a minute.

LO: How could it be exploitation?

TW: By just filming them and showing them on ITV and BBC. But you only had to talk to parents and staff to see that they weren’t being exploited, because they thought that it was wonderful to see what they were able to do. And that was my argument, I said: “If you want to see what

clients with learning disabilities can do and actually for people to have more belief in them as human beings who can benefit from therapy and benefit from these sorts of things, make a video of it.” And it worked extremely well. Well this is mostly anecdotes, you know, but I still go back to the beginnings, when I was inspired by Juliette Alvin and how we were working with clients and how we were working with other staff also. She was quite a dominating French lady. Did you meet her?

IN: Yes, once, for an interview once.

TW: Then she would come and say: “No, Tony, you must do this – you must work hard with this.” With this French accent she had, but she was extremely supportive of different styles of music therapy. She wasn’t analytical all the time. And she wasn’t behavioral all the time. She was quite varied in her work. When she worked at the Marlborough Road Autistic Centre in North London, she was quite able to be structuring with autistic clients.

LO: You wanted to tell another story about Juliette?

TW: It was the time when I was busy trying to establish good enough pay scales for music therapists in London. I spent a lot of energy trying to build up a good enough pay-structure for music therapy. Anyway, we had the Music Therapy Association in London, and Juliette Alvin came to one meeting, and it was preparing for a conference in London. She was proposing that the music therapists would all make a workshop, right? So when she proposed that, I said: “That’s fine Juliette, as long as you pay them.” She said: “I don’t understand what you mean, Tony,” and I said: “Well if you’re asking people to do a three

hour workshop on a Saturday afternoon, you need to pay them.” Her face was a picture: “I don’t understand why I should have to pay them? After all I am giving them a fantastic opportunity.” I said: “Yes, but after all it costs money, doesn’t it?” We argued about it at this meeting, and in the end she agreed. I said: “These people are giving up their Saturday afternoon, they need £70 for what you want them to do, especially when you’re bringing in 40 people to take part in this conference. And they’re all paying, so why shouldn’t...?” She said: “You have the mentality of a trades official.” I said: “That’s good Juliette, I like that.” So we had these really funny arguments actually. And she knew damn well what I was talking about anyway.

ASSESSMENT: DOCUMENTING THE EFFECT OF MUSIC THERAPY

LO: When did the assessment come in? Was it already at Harperbury, or when did you start being interested in assessment?

TW: From the very beginning. I was trying to count numbers – trying to count up how many times the client played for a period of seconds on a particular subject. You know I was trying to measure how much their attention was going on, how much their engagement was going on and how good their rhythmic patterning was. I had loads of forms I used to fill in with numbers on them. Ann Sloboda called me “the numbers man” [laughter]. But I was actually trying to keep a record of what was going on. And I thought: “Well, one way of doing it is measuring how well they’re able to play in patterns and how much they are able to play for a period of time before they stop playing,

how long their attention span is, how long their engagement with us is,” and I was keeping a lot of records.

LO: Did you publish anything on that in those days?

TW: No, I think I just had loads and loads of pages with tables in them [laughter]. I have some of these forms I was filling in, yes. They are papers like registration forms of how much clients played, how much time they played for before they stopped. How many times they played rhythmic patterns, and all sorts of things like that. I wanted people to know that music therapy wasn’t just playing around. I wanted them to know it was a serious way of collecting data and of helping people and recording what they were able to do. I kept records of all of that, because I wanted to demonstrate that music therapy was a way of calming people down or relaxing people or all those sorts of things.

IN: I remember you and Leslie [Bunt] presented that, isn’t that true. In Paris 1983? TW: Yes, well I presented it in Paris in ’83, the music and movement protocol, that I’d developed, which also documented how people were working, how long they were able to manage music and movements. It was, for me, a period where I started to get into documentation and felt it was important to show what they were able to do by counting to a certain extent. And it was of course not very interesting, for some people who were more interested purely in the emotional dynamic response people were making.

LO: Was it your idea to document the progress?

IN: or the attention span?

TW: Yes, attention span, interest and rhythmic pattern ability – lots of different aspects. I was trying to show how the progress was coming in the way you could document it. I realised quite early on, that the people in Harperbury – the doctors – they were becoming more interested in when I could actually show a number. This client played for this period of time and concentrated for this period of time, and showed this level of interest in what the therapist was doing and the session lasted this long compared to this long. You know, simple things, not complex. I thought it was quite important actually.

LO: Was it both individual and group work?

TW: It was a mixture of group and individual. I was then working a lot more with individuals, but also with groups, because I wasn’t prepared to just work with groups. I needed time with individuals, so I could actually have some more case studies to present. And after a while you get a bit tired of group work. It becomes a bit overwhelming, even though people like it. It’s just too much to do it all the time. I built an argument about the group work anyway, saying that you were sometimes more likely to get good responses in group work than in individual work.

LO: And it was also a way to engage the staff?

TW: Yes, it’s a way to engage the staff when a lot of people start working together in a group situation. Then sometimes people get fired up about it and find it, you know, a good experience. And

if you’re careful about it, you can draw everybody in. And I was trying to be careful about it. I wasn’t just bashing out old numbers and waiting to see who’d join in with the tempo. Many of my music therapy colleagues didn’t really think it was such a good way of working. They felt that group work was not good enough to pay attention to the individual, that you couldn’t give individual attention. It was better to just work with four clients and give them intensive individual attention, rather than working with 10 or 20 clients, and I would sometimes say: “No, I can see that the clients working in groups were actually doing better than when you were trying to work with them as individuals, because they just couldn’t handle that type of individual attention.” It was an argument I built for the autistic population, and for clients with learning difficulties, who had difficulty with being in too much attention. Because when they were in groups, they didn’t have to deal with too much pressure. It may sound odd, but the point is that if you had groups of people with autism and challenging behaviour, if they got too much individual attention they’d simply go: “Go away please, go away,” because they couldn’t cope with it. And I got hit several times, you know. So it was sometimes worth working in smaller groups. That was actually why I went to the USA. I got a fellowship to investigate the effect of music therapy on people with aggressive and difficult behaviour. So I went to the USA to find out how the therapists there dealt with it. And of course all I found out was that they worked totally behaviourally, whilst I was doing the opposite. I was doing it psychodynamically, so if clients got aggressive with me, there had to be a reason for it, and I had to engage with them and find

out what they could cope with, and what I could help them cope with. Aggressive and challenging behaviour is very difficult for anybody to deal with, and the staff had to deal with it. There was a lot of biting and scratching and kicking there. I had actually set up groups of therapy sessions for clients with aggressive and difficult behaviour. I set up special therapy groups, including clients who had problems with hearing and clients with very severe and odd syndromes, many different syndromes. So this was the story of many of my clients at Harperbury. And every single group I had to find ways of dealing with.

LO: But when you came to America, you found that no one was working that way?

TW: There wasn't anybody working the way I was working with aggressive and difficult clients, because what they were doing was behavioural control to stop them being aggressive. And MY argument with them was that you have to build up an emotional relationship with the clients, and a musical relationship with the clients. THEN you might have a chance of helping them cope with behaviours that they couldn't deal with. Because, I mean, they couldn't help it. And I was just busy trying to help - especially help my staff realise that building an emotional relationship was likely to be more successful than establishing a behavioural management strategy, which was what the Americans did. I enjoyed working with the clients, and I think if you get kicked a few times, it's good therapy for you.

LO: It's an expression of love isn't it?

TW: Yes, exactly. And that's why, you know, I was trying to give to the staff my atti-

tude: "They're people, that's all they are. It's not their fault they kick people." You know?

IN: So this means that you sometimes had a group of aggressive clients together? Didn't they attack each other?

TW: No, no it depends on how you manage them. I had groups including clients who were self-aggressive, you know, self-injuring, self-harming patients. I think the music helped them cope with it a lot. And I do also believe that the structure in the music is important. When people hear the structure in the music, they become more contained. So I did a lot of that. And I do believe the music did, not control, but enable people to hear structure that they could use, and not be offended by. But there was another aspect I suppose, it was if you over-stimulated, you'd also get the opposite reaction. The music and movement thing was also interesting. Lyn Weekes [who was a physiotherapist I worked with for many years] and I built a whole programme of music and movement, because I actually knew I had to learn about body movements and music and movements. You can't make people do difficult movements with their bodies unless you understand what they're trying to do. And, you know, you have to be careful about that. That's another level of professionalism I think. I'm certainly experiencing it now with my physiotherapy.

I did actually do some things with trying to develop a speech and language method, and I did things like using amplified microphones for example in order to help clients hear better what they were doing. So if you put an amplified microphone in front of one or more clients, and they

make noises and they hear their sounds, then they would start to respond to their sounds, and then you could make your sounds. I did all sorts of funny things with that - they would hear the amplification of their sound, and they would laugh at it, and then I would play it back to them so I recorded the amplification they made. And they would hear their amplified sounds. And this was, of course, very amusing and interesting for them as a recording of their sounds, because I realised early on that the clients needed to hear the sounds they were making, because they couldn't hear them. So I had to make them louder. And the reason that they needed to hear them is they needed to hear themselves, you know, and the music. And it was better for them to hear an amplified recording of those sounds that I'd made, than for me to try and artificially make a copy or something. So these things were actually quite good, and we spent a lot of time trying to make these sorts of technology into the work we were doing. Quite interesting.

IN: Did you ever work with building instruments for multi-handicapped people?

TW: No. Do you know why? Juliette Alvin told me not to [laughter]. I'm not joking, it's serious. The point was, when I first went to Harperbury, I bought lots of instruments, and I always argued to the staff, because they said: "Why do you need so much money for instruments." And I said: "Because I have to buy good quality instruments for them." Something I learned from Juliette is that if you give them bottles with stones in them, they very quickly know what the difference between bottles with stones in and a nicely sounding beautifully resonant Djembe or something like that. I said: "You

can't give people, even the very handicapped, rubbish instruments. You don't fill bottles with stones. It's not good." So we had to raise money for that. But as soon as the staff at Harperbury found out how interesting it was with the music, the first thing they did was to go out and buy stupid little instruments, stupid little tambourines, which make stupid little jingle sounds, you know, and I said: "Don't buy those," and they said: "But we can get ten tambourines and six small drums for this much money." And I said "Yes, but it will have NO meaning to these clients." I had to teach them that the power of a good quality sound is better than lots of stupid little sounds.

POLITICS: BUILDING A FRAMEWORK FOR THE PROFESSION

TW: The other role I suppose I haven't told so much about - but you probably know quite a lot about it anyway - is my political role in the services in North West Herts and all the political responsibilities I had as the head of the service there. And this isn't something music therapists are often doing. Some music therapists do this, but I was doing it right from the beginning. And I became, quite early on, the principal music therapist for the service there and for the hospital management service. And I had responsibilities as a sort of music therapy politician. I was quite happy to do that, and I became known for that work. And I think that was important, because then people could see that my job as a music therapist was far extended beyond purely banging on drums and playing cymbals, you know. This also gives you more status, as I think people realise that you've got more to do than just your clinical work.

LO: Early on you engaged yourself in building international professional associations – the World Federation [WFMT] and the European committee [EMTC]. Did you have specific goals for the political work?

TW: It came from a little group of therapists that met at Harperbury, people like Helen Odell-Miller, Gianluigi di Franco, myself and Patxi del Campo. And we all sort of put our hands together and said: “We’re now forming the European Music Therapy Committee.” And why were we doing it? Well, probably to build a power-base for ourselves. And there’s nothing wrong with that. People always criticise that sort of thing, but I’ll say: “Yeah, well actually we are, but we’re doing it to build something. There’s nothing wrong with that as long as people aren’t excluded from it – which they weren’t.” And what was it really for, the EMTC? It was to build structures – we made lists, we made committees, more committees, and we tried to make something that worked out. European Music Therapy Committee, what a name! So it was a committee, it was a group of people who were trying to build a sort of direction for music therapy amongst well meaning colleagues, which included quite a lot of people, so I think it was inclusive rather than exclusive. A lot of people signed up to it, said: “This is a good idea.” And our first few meetings had, you know, a lot of people. And of course it was built on the idea that there would be a representative from every one of the countries of Europe on the EMTC – I said: “We need that.” But the difficult thing about that was of course that it was very difficult for people to agree who that representative should be. Some stupid power people actually didn’t contribute anything to it. All they wanted was to have

their name on the paper and to have their place on the committee, arguing. And at one point I did lose it a bit. I said to people: “You can’t just come to the committee in this room and sit there and expect people to listen to you, if you don’t do any work for it.” I get fed up with people who want to have a position of power, but actually don’t do any work. And I made that very clear to some people, so probably I was unpopular. And I was probably unpopular because I could be quite argumentative with people in committee meetings, if I thought they weren’t doing much or if I thought they weren’t really giving any inspiration.

LO: How much did you discuss the cultural diversity? I mean there are so big differences between music therapy traditions in the different European countries. How much was that discussed in the early days?

TW: Never, never in the early days, I don’t think. It came up later, but it wasn’t really an issue. People like Gianluigi were very aware of it, and he would talk about it. And we talked about the differences in the way people worked to some extent, but I would say not to a great extent, which was a shame. We were all too busy trying to build up a structure, you know, trying to build up a concept and a group of people who were prepared to work together, to actually get into any depth about the cultural diversity. But I think people did talk a little bit about it, but not as much as they should have done.

IN: But you made registers, for example the music therapy research register.

TW: Yeah, that’s right, and there were of course arguments about what criteria you had to have involved, to be registered on some of these things. But, on the whole, it was open. I can say that. If people could present some good enough documentation, if they had done a music therapy qualification of some sort – and that was difficult of course – then they were included. We were more open than closed, I can say. We always had lots of people who hadn’t done a music therapy qualification, so what would you do with people like them? I knew, in the back of my head, that I was facing lots of people saying: “Why are you letting these people be involved?” And: “Why are you recognising these people – these Italians and these Dutch and other people who haven’t got qualifications?” And I just said: “Because it is better to recognise that they are trying, or something, than to exclude them. We’ll only end up with a disaster if we say: You can’t be in it, you’ll be excluded.”

LO: Looking back at it, was that the right way to do it? Do you think that today?

TW: For Europe and for UK and for what we were trying to do here, I think it was the right way to do it. Because if we had said: “Right, now we are going to make a whole list of criteria you have to produce in order to have your name on the list and to be recognised,” we wouldn’t have got anywhere, nowhere at all. I strongly believe that, and people will probably always criticise me for being too permissive in that sense and for not establishing good enough standards. And if I had to do it again, I probably would of course know better what to do in terms of establishing standards, but in the 1980s we had to allow some things. Even Juliette Alvin

would allow a lot of things as a form of music therapy. That’s the way it was then. You can’t just exclude people, you have to work with them, and encourage them, is my attitude.

IN: I think a lot of people will be thankful to you Tony. Thankful that you were so permissive.

TW: Yeah. I hope so.

LO: So you mean that starting with defining the standards and then excluding everyone who does not live up to that – is a bad way to build an organisation?

TW: Well, it is until you actually have got agreed things in place that everybody signs up to. You know, you don’t have to keep inventing the wheel. You can say: “What we know now, what it is and what it should be, so let’s do what it should be.” But at that moment in time, we didn’t have [that knowledge].

LO: One of the really big achievements of EMTC has been the European conferences. And looking back at all the conferences you’ve attended, what do you think it has evolved into? What is the situation today as compared to 20 years ago?

TW: I think the situation we’ve got to is a level of inclusivity certainly, whereas we can say 20 years ago there were people who were not prepared to be inclusive. On the other hand that leads to another problem which is, as I said just earlier, that people will be sometimes critical of who is being included, but I don’t mind that so much. I would often say to people who had presented papers at these conferences: “I really thought your intervention